Adult Wellness History

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Ashland Oregon 97520

Client Information

Your Name ___________________________________
Date of Birth __________________________________
Sex M F
Address _____________________________________
____
____
City________________________State_____________
Zip code______________________________________

Phone Number ________________________________

Social Security Number_______---______---_______

Email address __________________________________

Have you been to a chiropractor, naturopath or homeopath before ?__________

Who can we thank for referring you?
____

Are you under the care of another Physician? **Y N**
If yes Who?___________________________

Insurance Information

Insured's Name________________________________

Relationship to Patient__________________________

Insurance Carrier_______________________________

Responsible Party Information

Relationship to patient__________________________

Address_______________________________________

City ___________________State__________________
Zip Code______________________________________

Other Information

Occupation _______________________________
Employer__________________________________
Emergency contact__________________________
Emergency contact number____________________

Authorization for care

I have read the above information and certify it to be true and correct and to the best of my knowledge. I hereby authorize this office to provide me with chiropractic care, in accordance with this states' statutes

Patient or Guardian signature_______________________________________

Date________________________

To help us serve you please complete all of the following information.

Your Health History

What are ***your*** reasons for coming into the office today?

Are you under the care of another physician for another reason **Y N** if yes, for what reason?

Have you been hospitalized in the last 10 years? **Y N** If yes, for what reason?

Do you any mental or emotional disorders? **Y N** If yes, please explain.

Have you been traveling recently? If yes, where?

Please **list** all ***supplements/ herbs/ homeopathics/ vitamins*** you are currently taking or have you taken in the last year.

Please **list** all **medications** you are currently taking.

Do you:
Have any drug allergies? ☐ ☐ ______________________________
Have any food allergies ☐ ☐ ______________________________

HABIT	None	Light	Mod	Heavy		None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐	Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐	Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐	Sleep	☐	☐	☐	☐
Sugar	☐	☐	☐	☐	Exercise	☐	☐	☐	☐

Adult Past Health History

Doctor Chlebowski is interested in ***all aspects of your health.*** Please check the degree of all conditions you currently have or have had.

O = Occasional F = Frequent C = Constant

O F C

Muscle / Joint

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Neck pain, stiffness
☐ ☐ ☐ Pain between shoulders

General

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Anxiety
☐ ☐ ☐ Depression
☐ ☐ ☐ Loneliness
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors
☐ ☐ ☐ Mental Cloudiness

Cardiovascular

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heartbeat
☐ ☐ ☐ Slow heartbeat
☐ ☐ ☐ Swelling of ankles

Genitourinary

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Bladder infections
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Lack of kidney control
☐ ☐ ☐ Kidney infection
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

O F C

Eye, Ear, Nose and Throat

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noise
☐ ☐ ☐ Fullness in ears
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nose bleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Thyroid Problems
☐ ☐ ☐ Tonsillitis
☐ ☐ ☐ Vision Changes

Gastrointestinal

☐ ☐ ☐ Belching
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Bloated abdomen
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Empty feeling
☐ ☐ ☐ Gallbladder trouble
☐ ☐ ☐ Gas
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Heart burn
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

O F C

Skin

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins
☐ ☐ ☐ Nail fungus

Pain or numbness in

☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hand
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful tailbone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal curvature
☐ ☐ ☐ Swollen joints

Respiratory

☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficult breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Wheezing

Women only

☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excess menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Lumps in breast
☐ ☐ ☐ Menopause
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge
☐ ☐ ☐ Yeast Infections

Are you pregnant? ☐Yes ☐No
If yes, how many months?____
How many children do you have? ________

Check any of the following conditions you currently have or have had:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Atherosclerosis
☐ Asthma
☐ Cancer
☐ Chicken pox
☐ Cholera
☐ Cold sores
☐ Diabetes
☐ Eczema
☐ Edema
☐ Emphysema
☐ Epilepsy
☐ Fever blisters
☐ Goiter
☐ Gout
☐ Heart disease
☐ Herpes
☐ Influenza
☐ Lumbago
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Pacemaker
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Psoriasis
☐ Rheumatic fever
☐ Scarlet fever
☐ Shingles
☐ Stroke
☐ Suicide attempt
☐ Tuberculosis
☐ Ulcers
☐ Vaccination reaction
☐ Venereal disease
☐ Whooping cough

Family Health History

Information about your immediate family members (brothers, sisters, children, parents and grandparents) is crucial to our understanding of your total health picture.

Is there any family history of any of the following conditions? (circle please) Cancer / High Blood pressure / Tuberculosis / Psoriasis / Diabetes / Syphillis / Depression

Relationship **Alive/Deceased** **Age at death** **Present and Past health Problems**

MOM____

____

DAD____

____

BROTHERS____

____

SISTERS____

____

GRANDPARENTS____

____

CHILDREN____

____

Please rate your overall health on the line below

____

0 5 10

How much are you willing to work to improve your health?

____

0 5 10

How much interest do you have in learning about how to become healthier?

____

0 5 10

What do you believe is your biggest obstacle to achieving better health?

Is there any other information you would like to share with your doctor today?