Beyond Chiropractic New Patient History

To provide the best possible wellness care, please complete this form and bring it to your first appointment. All information is confidential.

Name _____ Date _____ Age _____ Height _____

Reason for office visit:_____
_____
_____
_____
_____

Date symptoms began:_____

Are you recovering from a cold or flu? _____ Are you pregnant? _____

List current health problems for which you are being treated:
_____
_____
_____
_____

What types of therapies have you tried for these problem(s) or to improve your health over-all:
☐ Diet modification ☐ Fasting ☐ Vitamins/Minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs
☐ Other _____

Current medications (prescription or over-the-counter):
_____
_____
_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):
_____

Outcome
_____
_____
_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year Surgery	Illness	Injury Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Just Right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)?
_____

What are your current health goals: _____
_____
_____
_____

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue ☐Shortness of breath ☐Insomnia ☐Constipation ☐ Chronic pain/inflammation

☐Depression ☐ Panic attacks ☐ Nausea ☐ Fecal incontinence ☐ Bleeding

☐ Disinterest in sex ☐Headaches ☐ Vomiting ☐ Urinary incontinence ☐ Discharge

☐Disinterest in eating ☐ Dizziness ☐ Diarrhea ☐ Low grade fever ☐ Itching/rash

Medical History

☐ Arthritis
☐Allergies/hay fever
☐Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Autoimmune disease
☐ Blood pressure problems
☐ Bronchitis
☐ Cancer
☐ Chronic fatigue syndrome
☐ Carpal tunnel syndrome
☐ Cholesterol, elevated
☐ Circulatory problems
☐ Colitis
☐ Dental problems
☐ Depression
☐ Diabetes
☐ Diverticular disease
☐ Drug addiction
☐ Eating disorder
☐ Epilepsy
☐ Emphysema
☐ Eyes, ears, nose, Throat problems
☐ Environmental sensitivities
☐ Fibromyalgia
☐ Food intolerance
☐ Gastroesophageal reflux disease
☐ Genetic disorder
☐ Glaucoma
☐ Gout
☐ Heart disease
☐Infection, chronic
☐ Inflammatory bowel disease
☐ Irritable bowel syndrome
☐ Kidney or bladder disease
☐ Learning disabilities
☐ Liver or gallbladder disease (Stones)
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological problems (Parkinson's, paralysis)
☐ Sinus problems
☐Stroke
☐ Thyroid trouble
☐ Obesity
☐ Osteoporosis
☐ Pneumonia
☐ Sexually transmitted disease
☐ Seasonal affective disorder
☐ Skin problems
☐ Tuberculosis
☐ Ulcer
☐ Urinary tract infection
☐ Varicose veins
Other _____
_____

Medical (Men)

☐ Benign prostatic hyperplasia
☐ Prostate cancer
☐ Decreased sex drive
☐ Infertility
☐ Sexually transmitted disease
Other _____
_____

Medical (Women)

☐ Menstrual irregularities
☐ Endometriosis
☐ Infertility
☐ Fibrocystic breasts
☐ Fibroids/ovarian cysts
☐ Premenstrual syndrome (PMS)
☐ Breast cancer
☐ Pelvic inflammatory disease
☐ Vaginal infections
☐ Decreased sex drive
☐ Sexually transmitted disease
Other _____
Date of last GYN exam _____
Mammogram☐ + ☐ —
PAP ☐ + ☐ —
Form of birth control _____
# of children _____
# of pregnancies _____
C-section _____
Age of first period _____
Date - last menstrual cycle _____
Length of cycle _____ days
Interval of time between cycles
_____days
Any recent changes in normal menstrual Flow (e.g., heavier, large Clots, scanty) _____
☐ Surgical menopause
☐ Menopause

Family Health History (Parents and Siblings)

☐ Arthritis
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug addiction
☐ Eating disorder
☐ Genetic disorder
☐ Glaucoma
☐ Heart disease
☐ Infertility
☐ Learning disabilities
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological disorders (Parkinson's, paralysis)
☐ Obesity
☐ Osteoporosis
☐ Stroke
☐ Suicide
Other _____

Health Habits

☐ Tobacco:
Cigarettes: #/day _____
Cigars: #/day _____
☐ Alcohol:
Wine: #glasses/d or wk _____
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____
☐ Caffeine:
Coffee: #6 oz cups/d _____
Tea: #6 oz cups/d _____
Soda w/caffeine: #cans/d _____
Other sources _____
☐ Water: #glasses/d_____

Exercise

☐ 5-7 days per week
☐ 3-4 days per week
☐ 1-2 days per week
☐ 45 minutes or more duration per Workout
☐ 30-45 minutes duration per workout
☐ Less than 30 minutes
☐ Walk - #days/wk _____
☐ Run, jog, other aerobic - #days/wk
_____
☐ Weight lift - #days/wk_____
☐ Stretch - #days/wk_____
☐ Other _____

Nutrition & Diet

☐ Mixed food diet (animal and Vegetable sources)
☐ Vegetarian
☐ Vegan
☐ Salt restriction
☐ Fat restriction
☐ Starch/carbohydrate restriction
☐ The Zone Diet
☐ Total calorie restriction_____
Specific food restrictions:
☐ Dairy ☐ Wheat ☐ Eggs
☐ Soy ☐ Corn ☐ All Gluten
Other _____

Food Frequency
Number of servings per day:

Fruits (citrus, melons, etc.) _____
Dark green or deep yellow/orange Vegetables _____
Grains (unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

Eating Habits

☐ Skip meals - which ones _____
☐ One meal/day
☐ Two meals/day
☐ Three meals/day
☐ Graze (small frequent meals)
☐ Generally eat on the run
☐ Eat constantly whether hungry or not

Current Supplements

☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin E
☐ EPA/DHA
☐ Evening Primrose/GLA
☐ Calcium, source _____
☐ Magnesium
☐ Zinc
☐ Minerals, describe _____
☐ Friendly flora (Acidophilus)
☐ Digestive enzymes
☐ Amino acids
☐ CoQ10
☐ Antioxidants (e.g., Lutein, Resveratrol, etc.)
☐ Herbs
☐ Homeopathy
☐ Protein shakes
☐ Superfoods (e.g., Bee Pollen, Phytonutrient Blends)
☐ Liquid meals (Ensure)
Others:_____

I Would Like To:

ENERGY - VITALITY

☐ Feel more vital
☐ Have more energy
☐ Have more endurance
☐ Be less tired after lunch
☐ Sleep better
☐ Be free of pain
☐ Get less colds and flu
☐ Get rid of allergies
☐ Not be dependent on over-the counter Medications like aspirin, Ibuprofen, anti-histamines, sleeping Aids, etc.
☐ Stop using laxatives and stool Softeners
☐ Improve sex drive

BODY COMPOSITION

☐ Loose weight
☐ Burn more body fat
☐ Be stronger
☐ Have better muscle tone
☐ Be more flexible

STRESS, MENTAL, EMOTIONAL

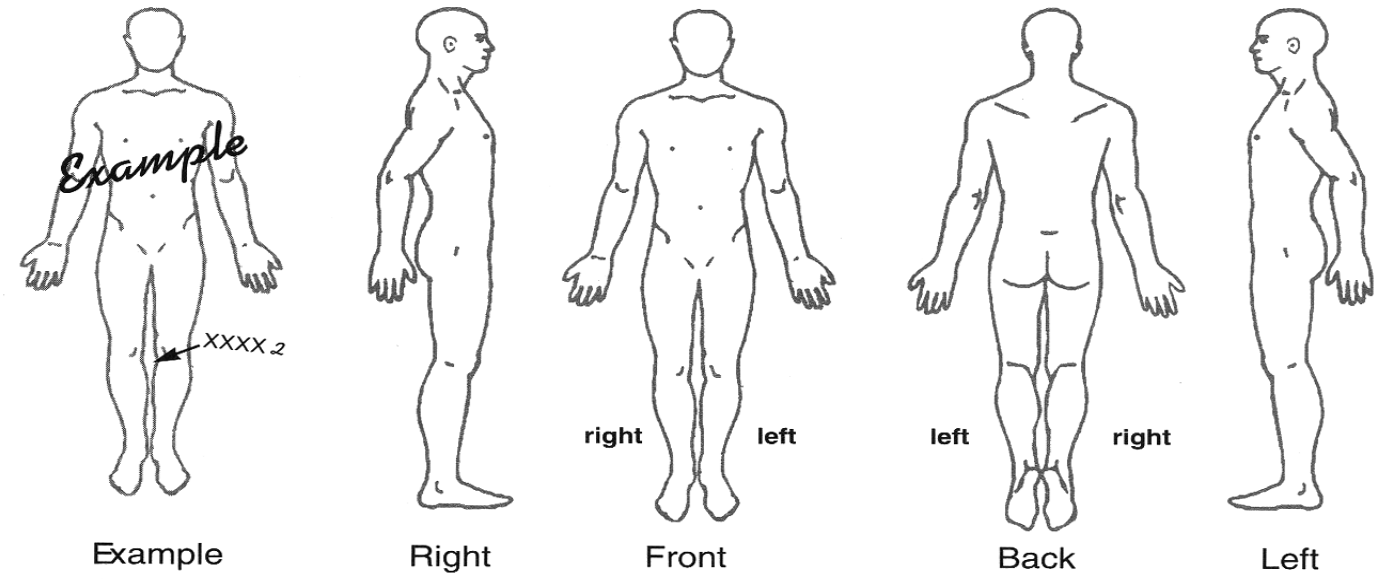
☐ Learn how to reduce stress
☐ Think more clearly and be more focused
☐ Improve memory
☐ Be less depressed
☐ Be less moody
☐ Be less indecisive
☐ Feel more motivated

LIFE ENRICHMENT

☐ Reduce my risk of degenerative Disease
☐ Slow down accelerated aging
☐ Maintain a healthier life longer
☐ Change from a "treating-illness" Perspective to a lifestyle of wellness

Please mark **area(s)** of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	OOOOO	^^^^^	X X X X X	●●●●●



Example Right Front Back Left

7/00, Rev 1/03, Rev 3/06 MET1392