Wellspring Chiropractic and Acupuncture Center

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Dear New Patient,

Welcome to Wellspring!! We look forward to helping you to achieve your health goals. Whether you desire simply pain relief or comprehensive wellness care, we are committed to helping you to achieve that result.

The following pages contain a very detailed health history form. Please complete this form as completely as possible. It is important that we have a comprehensive picture of your entire state of health so that the correct diagnosis and individualized treatment plan be designed for you. You may think certain questions are unrelated to your current condition, or are so far in the past that it's irrelevant. On the contrary, this information might be just what's needed to tailor your individualized treatment plan.

You may notice some differences in our approach to healing. We treat the whole person, not just a set of symptoms. We encourage you to take an active role in reclaiming your health, and we will guide you through that process. We will gladly work with your other health care providers, or refer you to one who can help you better. Once your acute condition is resolved, we expect you to maintain your health by practicing the health habits we have taught you, and to come in periodically for "seasonal tune ups."

We are deeply honored by your choice of Wellspring to help with your health care. We would like to make your experience here a positive one. Please let us know how we can better serve you.

Be well,

Dr. Bonnie Walker

Dr Amanda Peters

& Wellspring staff

Comprehensive Health History

Name_____Sex_____Age_____DOB_____/____/___

Describe your general state of health today._____

When did you last feel well?_____

What type of care do you desire?

- ☐ Temporary relief of symptoms / pain control
- ☐ Elimination of root/cause of problem, if possible
- ☐ Balanced optimum health care
- ☐ Maintenance /wellness care

How would you classify your condition?

- ☐ Minor
- ☐ Moderate
- ☐ Intensifying, affecting daily activities
- ☐ Fairly severe, progressively getting worse or more worrisome
- ☐ Serious

Please state and describe the problem(s) or condition(s) concerning you

 # 1 Problem _____

When did it occur?_____How? _____

Timing: Is it getting: better☐ worse☐ constant ☐ worsens@ what time?_____

What makes it worse?_____What makes it better? _____

Are there any other symptoms which occur along with this problem? No_____Yes _____

Describe other symptoms _____

 # 2 Problem _____

When did it occur?_____How? _____

Timing: Is it getting: better ☐ worse ☐ constant ☐ worsens@ what time?_____

What makes it worse?_____What makes it better? _____

Are there any other symptoms which occur along with this problem? No_____Yes_____

Describe other symptoms _____

 # 3 Problem _____

When did it occur?_____How? _____

Timing: Is it getting: better ☐ worse ☐ constant ☐ worsens@ what time?_____

What makes it worse?_____What makes it better? _____

Are there any other symptoms which occur along with this problem? No_____Yes_____

Describe other symptoms _____

Past Medical History

Please answer all questions as completely as possible, even though it may not seem relevant to your current condition.

Date of last physical exam:_____ Doctor_____

Results of exam _____

Weight_____ lbs. Height_____ Any recent changes?_____

 # Gain?_____ # Loss? _____

Do you have any allergies? No ☐ Yes ☐ Allergic To _____

Please list any other treatments you have tried (if any), practitioner and results

Condition treated	Type of treatment	Doctor or therapist's name	Results
	Chiropractic		
	Acupuncture		
	Medical Dr, Osteopath		
	Physical Therapy		
	Massage		
	OTC meds		
	Rx meds		
	Ice, Heat, etc.		

Medications currently taking or recently prescribed:

Name of drug	Prescribed for

SERIOUS ILLNESSES TRAUMAS, ACCIDENTS, SURGERIES, ETC.

List any which made you very ill, had high fever, recurred, required hospitalization or took long to resolve, and your age at the time. ***Include severe childhood and adult illnesses and hospitalizations for childbirth.***

Please answer all questions as completely as possible, even though it may not seem relevant to your current condition. In many cases, it is very relevant.

Problem #1 _____ **When (or age)** _____

Describe problem _____

_____

_____

_____

Problem #2 _____ **When (or age)** _____

Describe problem _____

_____

_____

_____

Problem #3 _____ **When (or age)** _____

Describe problems _____

_____

_____

_____

Problem #4 _____ **When (or age)** _____

Describe problem _____

_____

_____

_____

Problem #5 _____ **When (or age)** _____

Describe problem _____

_____

_____

_____

Problem #6 _____ **When (or age)** _____

Describe problem _____

_____

_____

_____

Indicate Average Use or Consumption

(*Please be honest… This information is confidential & very important*)

Please answer all questions as completely as possible, even though it may not seem relevant to your current condition. In many cases, it is very relevant.

Use of	*Type*	*Quantity*	*Frequency*
Alcohol			
Tobacco			
Sweets			
Artificial sweeteners			
Sodas			
Recreational drugs			
Coffee, tea, caffeine			
Water			
Exercise			
Meditation, yoga, or relaxation			

Level of stress you are currently experiencing: ☐ **Low** ☐ **Moderate** ☐ **High** ☐ **Extreme**

Blood type: ☐ **A** ☐ **B** ☐ **O** ☐ **A B** ☐ **Not sure**

Please describe your average daily diet:

Breakfast _____

_____

_____

Lunch _____

_____

_____

Dinner _____

_____

_____

_____

Snacks _____

_____

_____

Do you have specific food cravings? ☐ **No** ☐ **Yes**

What are they? ☐ **Sour** ☐ **Bitter** ☐ **Sweet** ☐ **Spicy** ☐ **Salty**

Other _____

When do they occur? _____

Comprehensive Health History

Indicate whether your symptoms are C=current H=history

Please answer all questions as completely as possible, even though it may not seem relevant to your current condition. In many cases, it is very relevant.

GENERAL

- ☐ Tremors
- ☐ Fever
- ☐ Sweats
- ☐ Fainting
- ☐ Convulsions
- ☐ Lack of sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Depression
- ☐ Confusion
- ☐ Compulsiveness
- ☐ Unexplained weight loss/gain
- ☐ Paralysis
- ☐ Numbness
- ☐ Pain (Where?)_____
- ☐ Addiction (To what?)_____
- ☐ Auto immune disease_____
- ☐ Seasonal affective disorder
- ☐ Mood swings
- ☐ Overweight
- ☐ Underweight
- ☐ Other_____

HEAD & FACE

- ☐ Discolorations
- ☐ Headaches
- ☐ Dizziness
- ☐ Memory loss
- ☐ Pain
- ☐ Paralysis
- ☐ Swelling
- ☐ Numbness
- ☐ Other_____

EYES

- ☐ Blurred, double vision
- ☐ Eyelid problem
- ☐ Eye pain
- ☐ Eye strain
- ☐ Nearsightedness
- ☐ Farsightedness
- ☐ Lazy eye
- ☐ Red, itchy, watery eyes
- ☐ Dry eyes
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Other eye problems

EARS

- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ear infections
- ☐ Ear discharge,
- ☐ Ear Itching
- ☐ Ringing, noises
- ☐ Other_____

NOSE AND SINUSES

- ☐ Frequent colds
- ☐ Nasal congestion
- ☐ Nasal discharge
  - Color of nasal discharge _____
- ☐ Itching
- ☐ Sores/lesions
- ☐ Nosebleeds
- ☐ Sinus congestion
- ☐ Diminished, loss of sense of smell
- ☐ Allergies to_____

Comprehensive Health History

MOUTH & THROAT

- ☐ Tooth problems
- ☐ Loss of sense of taste
- ☐ Unusual taste
- ☐ Gum problems
- ☐ Tongue problems
- ☐ Feeling of lump in throat
- ☐ Lip problems
- ☐ Jaw problems
- ☐ Speech problems
- ☐ Sores in mouth
- ☐ Teeth missing (how many?) _____
- ☐ Dentures / implants
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Lumps in neck
- ☐ Swollen glands
- ☐ Goiter (swollen thyroid)
- ☐ Neck pain
- ☐ Difficulty swallowing
- ☐ Stiff neck
- ☐ Burning in mouth
- ☐ Other_____

GASTROINTESTINAL/DIGESTION

- ☐ Excessive thirst
- ☐ No thirst
- ☐ Skin itching
- ☐ Excessive Hunger
- ☐ No appetite
- ☐ Difficulty chewing food
- ☐ Difficulty swallowing food/ water
- ☐ Heartburn / reflux
- ☐ Nausea
- ☐ Vomiting
- ☐ Belching / bloating / gas
- ☐ Stomach / abdominal pain

GASTROINTESTINAL/DIGESTION

- ☐ Flatulence (gas in bowels)
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Loose stools
- ☐ Constipation
- ☐ Hiatal hernia
- ☐ Parasites When ? _____
- ☐ Stomach / duodenal ulcer
- ☐ Black tarry stools
- ☐ Pale stools
- ☐ Liver problems
- ☐ Hepatitis (circle which type) a b c
- ☐ Rectal bleeding
- ☐ Jaundice
- ☐ Gallbladder problems
- ☐ Difficulty losing / gaining weight
- ☐ Recent rapid weight loss/gain #_____lbs
- ☐ Eating disorder
- ☐ Food intolerances / allergies
- ☐ Other_____

GENITOURINARY

- ☐ Difficulty urinating
- ☐ Burning or pain on urination
- ☐ Dribbling / leaking / incontinence
- ☐ Frequent urination
- ☐ Blood / pus in urine
- ☐ Discolored urine
- ☐ Nighttime urination #_____/night
- ☐ Bladder infections / cystitis
- ☐ Kidney stones
- ☐ Kidney infections
- ☐ Bedwetting
- ☐ *Oth*er _____

Comprehensive Health History

LUNGS

- ☐ Cough
- ☐ Sputum / phlegm
- ☐ Color
- ☐ Wheezing / asthma
- ☐ Difficulty inhaling or exhaling
- ☐ Allergies
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Emphysema / COPD
- ☐ Tuberculosis
- ☐ Pleurisy
- ☐ Shortness of breath
- ☐ Smoker_____pks / day for_____yrs
- ☐ Ex-smoker/_____quit (date)
- ☐ Date of last chest x-ray
- ☐ Other_____

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Palpitations
- ☐ Tightness / pain in chest
- ☐ Difficulty lying flat
- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ Irregular heartbeat
- ☐ Pain over heart
- ☐ Prior heart attack_____date
- ☐ Hardening of the arteries
- ☐ Prior stroke_____date
- ☐ Ankles swell
- ☐ Blood clots
- ☐ Rheumatic / scarlet fever
- ☐ Heart murmur
- ☐ Smothering sensations
- ☐ Date of last EKG_____

CARDIOVASCULAR (continued)

- ☐ Poor circulation
- ☐ Restless legs
- ☐ Varicose veins
- ☐ Thrombophlebitis
- ☐ Vein surgery
- ☐ Leg pains
- ☐ Cold hands
- ☐ Cold feet
- ☐ Hot hands
- ☐ Hot feet
- ☐ Other _____

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Lower back pain
- ☐ Painful tailbone
- ☐ Spinal curvature / scoliosis
- ☐ Bad posture
- ☐ Hernia
- ☐ Joint pain (Where?)_____
- ☐ Swollen joints
- ☐ Hot, inflamed joints
- ☐ Stiff joints (Where?) _____
- ☐ Arthritis
- ☐ Sciatica
- ☐ Foot trouble
- ☐ Difficulty walking
- ☐ Sore / tired / weak muscles
- ☐ Other_____

Sleep

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Awakened by pain/need to urinate/noise (Circle which)
- ☐ Reduced sexual desire
- ☐ Normally wakes @ _____
- ☐ Unrefreshing sleep
- ☐ Vivid / disturbing dreams
- ☐ Can't recall dreams
- ☐ Racing thoughts
- ☐ Need meds to sleep
- ☐ Other_____

NEUROLOGIC

- ☐ Fainting
- ☐ Blackouts
- ☐ Seizures
- ☐ Paralysis
- ☐ Numbness
- ☐ Tingling
- ☐ Tremors
- ☐ Dizziness/vertigo
- ☐ Tics/involuntary motions
- ☐ Other_____

HEMATOLOGIC

- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Past transfusions
- ☐ Transfusion reactions
- ☐ Leukemia When? _____
- ☐ Hemorrhage/blood loss_____age
- ☐ Other_____

SKIN

- ☐ Easy bruising
- ☐ Easy bleeding / slow clotting
- ☐ Excessively dry / oily skin (Circle which)
- ☐ Moles (color?) _____
- ☐ Wounds slow to heal
- ☐ Excessive sweating
- ☐ Rarely sweat
- ☐ Night sweats
- ☐ Skin rashes
- ☐ Other_____

ENDOCRINE

- ☐ Underactive thyroid
- ☐ Overactive thyroid
- ☐ Graves disease When? _____
- ☐ Hashimoto's thyroiditis When? _____
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive sweating
- ☐ Diabetes When? _____
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Other_____

MENTAL / EMOTIONAL

- ☐ Nervousness
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Stress(describe)
- ☐ Depression
- ☐ Memory loss
- ☐ Anger/irritability
- ☐ Loss of zest for life
- ☐ Low self esteem
- ☐ Mood swings
- ☐ Feeling overwhelmed
- ☐ Suicidal thoughts or plans
- ☐ Other_____

Comprehensive Health History

FEMALE

- ☐ Painful menses/ovulation
- ☐ Bleeding light/moderate/heavy
- ☐ Clotting/dried brownish blood
- ☐ Monthly cycle is every___days
- ☐ Bleeding is_____days
- ☐ Spotting_____When?
- ☐ Menopausal symptoms
- ☐ Hot flashes
- ☐ Irregular cycle_____
- ☐ Vaginal discharge
  Color?_____Odor? _____
- ☐ Vaginal dryness
- ☐ Breast swelling
- ☐ Breast pain
- ☐ Pelvic/vaginal pain
- ☐ Sexually transmitted disease
  Which? _____
- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Breast cysts
- ☐ Last pelvic exam
  Date _____
- ☐ Self breast exam
  How often? _____
- ☐ Are you pregnant?
  Circle one Yes No Maybe
- ☐ Birth control
  method_____
- ☐ Difficulty / pain achieving orgasm
- ☐ Age @ start of menses
  _____
- ☐ Date of last menstrual period
  _____

FEMALE (continued)

Pregnancies #_____
Deliveries #_____
Abortions #_____
Miscarriages #_____
Complications_____
Gynecological surgeries _____

- ☐ History of rape/sexual abuse
- ☐ Other_____

MALE

- ☐ Genital pain
- ☐ Lesions/sores on genitals
- ☐ Swelling/lump on genitals
- ☐ Difficulty with erection
- ☐ Decreased desire for sex
- ☐ Premature ejaculation
- ☐ Difficulty/pain achieving orgasm
- ☐ Infertility/low sperm count
- ☐ Testicular self-exam
  How often?_____
- ☐ Trauma/injury to testes
- ☐ Vasectomy
- ☐ Varicocele
- ☐ Other_____

Congratulations on completing your health history form. Now that you have had time to reflect on your health history, is there anything you may want to add for Dr. Walker's evaluation?

I declare that the medical history provided herein is accurate and complete, to the best of my recollection. If any other details come to mind at a later date I will inform Dr Walker immediately. I will not hold Dr Walker, Dr Peters or Wellspring Chiropractic and Acupuncture Center responsible for any misdiagnosis made as a result of my providing inaccurate or incomplete information.

Signed_____ **Date**_____