LiveWell Chiropractic Health Center

Chiropractic • Physical Therapy • Nutrition

Name _____ Age _____ Date _____

Health Concerns

What are your major health problems/concerns, (even if you do not consider them related to chiropractic care they give us an insight into what is going on with your nervous system and brain)? If you have none and are coming to us for wellness care, please list some of your primary concerns.

Date of onset _____ Using the lines below please give brief description:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

What are the goals you hope to achieve as a result of working with us?

1. _____
2. _____
3. _____

Medical History

Please list any medical conditions/illnesses you have now or have had in the past, as well as the year you were diagnosed: ☐ None

Please list any hospitalizations or surgeries you have had along with the year you had them: ☐ None

Please list any automobile accidents you were involved in and any lingering effects: ☐ None

Do you have any known allergies (medications/supplements/latex etc.)? ☐ None

Symptom checklist - Please check all symptoms

Eyes

- ☐ Watery Eyes
- ☐ Itchy Eyes
- ☐ Swollen Eyelids
- ☐ Blurred Vision
- ☐ Dark Circles

Skin

- ☐ Acne
- ☐ Hives, rashes
- ☐ Hair Loss
- ☐ Flushing/Hot flashes
- ☐ Excessive Sweating

Mind

- ☐ Poor Memory
- ☐ Confusion
- ☐ Poor Concentration
- ☐ Stuttering/Stammering
- ☐ Learning Disabilites

Energy

- ☐ Fatigue
- ☐ Sluggishness
- ☐ Apathy
- ☐ Hyperactivity
- ☐ Restlessness

Ears

- ☐ Itchy Ears
- ☐ Ear Aches
- ☐ Ear Infections
- ☐ Drainage from Ears
- ☐ Ringing in Ears

Heart

- ☐ Irregular Heartbeat
- ☐ Rapid Heartbeat
- ☐ Chest Pains
- ☐ Frequent Illness
- ☐ Urgent Urination

Emotions

- ☐ Mood Swings
- ☐ Anxiety, Fear
- ☐ Irritability, Anger
- ☐ Depression
- ☐ Aggressiveness
- ☐ Nervousness

Joint/Muscles

- ☐ Feeling of Weakness
- ☐ Pain in Joints
- ☐ Arthritis
- ☐ Stiffness
- ☐ Limited Movement
- ☐ Aches in Muscles

Nose

- ☐ Stuffy Nose
- ☐ Sinus Problems
- ☐ Hay Fever
- ☐ Sneezing Attacks
- ☐ Excessive Mucous

Lungs

- ☐ Chest Congestion
- ☐ Asthma, Bronchitis
- ☐ Shortness of Breath
- ☐ Difficult Breathing

Head

- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness
- ☐ Insomnia

Women

- ☐ Menopause
- ☐ Low Libido
- ☐ Freq Yeast Infection
- ☐ UTI's
- ☐ PMS

Mouth/Throat

- ☐ Chronic coughing
- ☐ Dry Mouth
- ☐ Often Clear Throat
- ☐ Sore Throat
- ☐ Swollen Tongue/Lips
- ☐ Canker Sores

GI Tract

- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Belching
- ☐ Passing Gas
- ☐ Stomach Pains

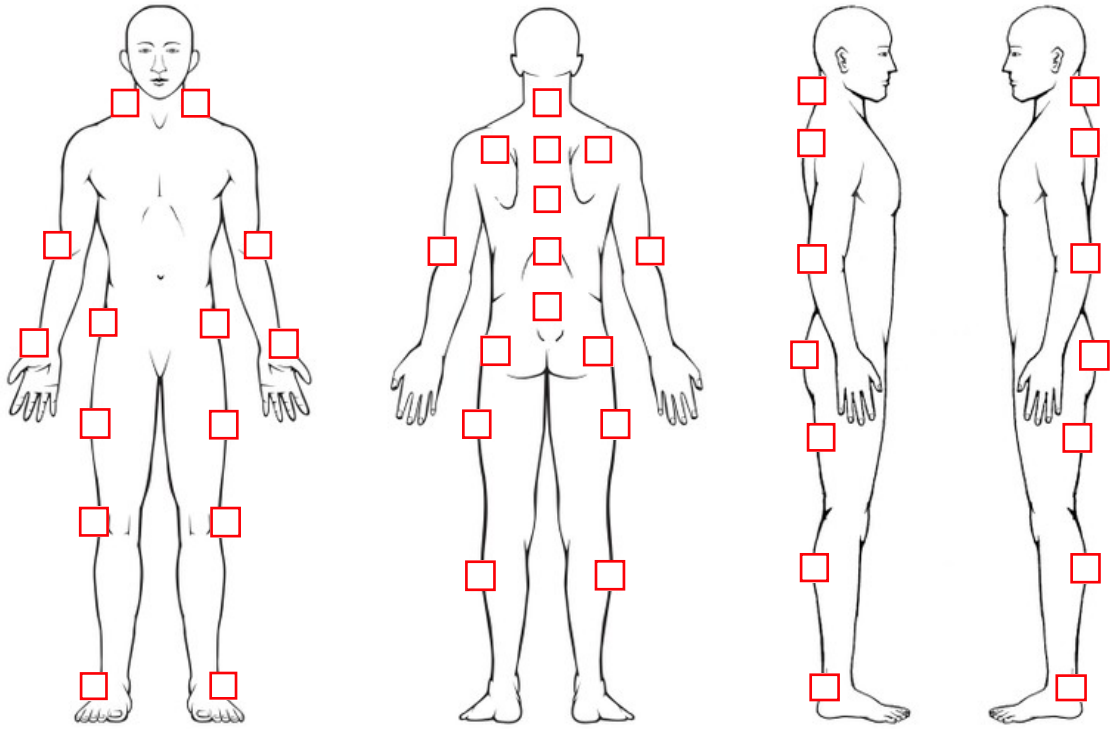
Weight

- ☐ Binge Eating
- ☐ Cravings
- ☐ Excessive Weight
- ☐ Underweight
- ☐ Water Retention

Men

- ☐ Erectile Dysfunction
- ☐ Low Libido

If you are coming in for chiropractic care, please indicate the location of your problems on the figures below.



Tell us about your problem areas, or list an area not indicated above:

Have you had previous chiropractic care?

☐ Yes ☐ No

If yes did you find it effective?

☐ Yes ☐ No

If your condition involves pain, please characterize type:

☐ Ache
☐ Sharp
☐ Radiating
☐ Intermittent

Did you undergo any treatments?

☐ Yes ☐ No

If yes please list the name of the treatment:

Please list and prescription or non-prescription drugs you are taking: ☐ None

Please list any vitamins/supplements/herbs you are taking: ☐ None

Do you smoke? If yes, how long/much? ☐ None

Alcohol use? If yes, how long/much? ☐ None

Family Health History: If you are adopted and don't know check here ☐

Please review the conditions listed below. Indicate those that are current health problems of a family member by writing the letter **C** under his/her column. Use a letter **P** to indicate a past problem. Spaces that do not apply should be left blank.

Condition	Father Age	Mother Age	Spouse Age	Brother/s Age	Sister/s Age	Children Age
Alcoholism/Addiction						
Alzheimer's Disease						
Allergies/hay fever						
Arthritis						
Asthma						
Cancer (indicate type)						
Depression						
Diabetes						
Digestive problems						
Heart disease						
High blood pressure						
Insomnia						
Kidney problems						
Liver disease						
Mental health problem						
Migraines						
Osteoporosis						
Other (indicate)						
Other (indicate)						

If any of the above family members are deceased, please list their age at death and cause:

Please list any other major conditions that run in your family:

Diet

Caffeine ?

☐ Yes ☐ No

If yes how much per day? _____ per week? _____

What kind? Coffee, Soda, Chocolate? _____

How many servings of bread do you eat daily? _____ weekly? _____

How many serving of fast food do you eat daily? _____ weekly? _____

How many servings of sugary snacks do you eat daily? _____ weekly? _____

How many serving of vegetables do you eat daily? _____

How many servings of fruit do you eat daily? _____

How many servings of meat do you eat daily? _____

How many times a day do you have a bowel movement? _____

Sleep Evaluation: (please mark Yes or No)

1. _____ Do you have trouble getting to sleep?
2. _____ Do you have trouble staying asleep, awaking every few hours?
3. _____ Do you feel fatigued or groggy when you get up in the morning?
4. _____ Is it hard to wake up and get going in the morning?
5. _____ Are you sleepy during the day?
6. _____ Do you snore loudly?
7. _____ Are you substantially overweight?
8. _____ Has anyone witnessed you sleeping, and noticed that you regularly stop breathing for several seconds or longer?
9. _____ Do you wake up with a sore throat or headache very often?
10. _____ Do your arms or legs make abrupt, jerky movements when you're in bed? (This is called Periodic Limb Movement Disorder)
11. _____ Do you have uncomfortable, tingly, achy or creepy-crawly feelings in your legs when you lie down? (This is called Restless Leg Syndrome)
12. _____ Are you awaked by night sweats, or from being too hot?

Miscellaneous

1. _____ Do you have any mercury fillings in your teeth?
2. _____ Do you get cold hands or feet on a regular basis?
3. _____ Do you bruise easily?