

# Medical History Information

<b>Date:</b>				<b>Doctor:</b>				
Last Name:			Middle:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one)	
First Name:					<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Widow	
Birth date:		Age:	Race:	Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female		
SS#:		Driver's License #:			Email:			
Home Phone:			Cell Phone:		Work Phone:			
Address:				City:		State:	ZIP Code:	
Employer:			Occupation:			Years on Job:		
Name of Spouse, Parent or Guardian:				Spouse Employer:				
Does Your Spouse Have Health Insurance at Work? <input type="checkbox"/> No <input type="checkbox"/> Yes				Birth date:				
Describe the Major Complaints That Brought You to Our Office:								
Is Your Condition Due to an Accident? <input type="checkbox"/> No <input type="checkbox"/> Yes								
Is This Due to: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other:								
Days Lost From Work:				If Yes, Date of Accident:				
Have You Ever Had the Same or a Similar Condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____								
1. If This is A Recurrence, When Was the First Time You Noticed This Problem?								
How Did it Originally Occur?								
Has it Become Worse Recently? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Gradually Worse								
If Yes, When and How?								
2. How Frequent is the Condition? <input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Intermittent <input type="checkbox"/> Night Only								
3. How Long Does the Condition Last? <input type="checkbox"/> All Day <input type="checkbox"/> A Few Hours <input type="checkbox"/> Minutes								
4. Are There Any Other Conditions or Symptoms that May Be Related to Your Major Symptom? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____								
5. Are There Other Unrelated Health Problems? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____								
6. Please Describe the Pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling								
<input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Stabbing <input type="checkbox"/> Other?								
7. Is There Anything You Can Do to Relieve the Problem? <input type="checkbox"/> No <input type="checkbox"/> Yes								
If Yes, Please Describe:								
If No, What Have You Tried to do That Has Not Helped?								
8. What Makes the Problem Worse? <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Lying <input type="checkbox"/> Bending								
<input type="checkbox"/> Lifting <input type="checkbox"/> Twisting <input type="checkbox"/> Other								
<b>Wellness Commitment</b>								
At Beyond Wellness, we are dedicated to achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do ask for your cooperative commitment. Based on a scale of 10% - 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.								
10%---20%---30%---40%---50%---60%---70%---80%---90%---100%								
<b>Review of Symptoms:</b>								
9. Do you have skin, hair or nail problems?				<input type="checkbox"/> No <input type="checkbox"/> Yes, _____				
10. Do you have mouth and/or throat problems?				<input type="checkbox"/> No <input type="checkbox"/> Yes, _____				
11. Do you have nose and/or sinus problems?				<input type="checkbox"/> No <input type="checkbox"/> Yes, _____				
12. Do you have ear problems?				<input type="checkbox"/> No <input type="checkbox"/> Yes, _____				
13. Do you have eye problems?				<input type="checkbox"/> No <input type="checkbox"/> Yes, _____				
14. Do you have chest or lung (breathing) problems?				<input type="checkbox"/> No <input type="checkbox"/> Yes, _____				
15. Do you have heart and/or blood vessel problems?				<input type="checkbox"/> No <input type="checkbox"/> Yes, _____				
16. Do you have blood or lymph problems?				<input type="checkbox"/> No <input type="checkbox"/> Yes, _____				
17. Do you have digestive problems?				<input type="checkbox"/> No <input type="checkbox"/> Yes, _____				
18. Do you have genital problems (e.g., prostate, testicular, vaginal)?				<input type="checkbox"/> No <input type="checkbox"/> Yes, _____				

- |   |                             |                                     |
|---|-----------------------------|-------------------------------------|
| 19. Do you have urinary (including kidney or bladder) problems?                           | <input type="checkbox"/> No | <input type="checkbox"/> Yes, _____ |
| 20. <b>Females</b> , have you had menstrual problems?                                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes, _____ |
| Have you ever taken birth control pills?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes, _____ |
| Is there any chance that you are currently pregnant?                                      | <input type="checkbox"/> No | <input type="checkbox"/> Yes, _____ |
| Do you have any breast problems?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes, _____ |
| 21. Do you have any nervous system diseases and/or mental health problems?                | <input type="checkbox"/> No | <input type="checkbox"/> Yes, _____ |
| 22. Do you have any gland and/or hormone problems?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes, _____ |
| 23. Do you have allergy or immunity problems?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes, _____ |
| 24. Do you have any muscle, tendon or ligament problems?                                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes, _____ |
| 25. Do you have any bone or joint diseases (examples: bone=osteoporosis, joint=arthritis) | <input type="checkbox"/> No | <input type="checkbox"/> Yes, _____ |

### Past History:

26. List any diseases that you have had in the past, including childhood diseases: \_\_\_\_\_
27. Tell us if you have ever been diagnosed as having a particular condition, such as diabetes, cancer, AIDS, etc.: \_\_\_\_\_
28. Have you suffered any physical injuries, such as fall or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, dislocations, broken or cracked bones?  No  Yes, \_\_\_\_\_
29. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_
30. Have you ever been hospitalized for any reason other than surgery?  No  Yes, \_\_\_\_\_
31. **Medications**, Please list all medications (prescription and non-prescription) you are currently taking or take on an occasional basis: \_\_\_\_\_
32. **Supplements**, Please list all the nutritional and vitamin supplements you are currently taking or take on an occasional basis: \_\_\_\_\_

### Medical Care Information

33. Do You Have a Family Doctor?:  No  Yes, Name of Doctor: \_\_\_\_\_
- Address: \_\_\_\_\_
- Date of last Visit: / /
34. Do You Have a Family Chiropractor?:  No  Yes, Name of Chiropractor: \_\_\_\_\_
- Address: \_\_\_\_\_
- Date of last Visit: / /
35. Have you had surgeries in the last 5 Years:  No  Yes If yes, Last Surgery Date: \_\_\_\_\_
- Reason for Surgery: \_\_\_\_\_
36. Have You Been Treated for any Health Condition by a Physician in the Last Year?:  No  Yes, \_\_\_\_\_

### Social History

37. In what position do you sleep, and how well? \_\_\_\_\_
38. Do you exercise on a regular basis?  No  Yes, Hours per day? \_\_\_\_\_  Light  Moderate  Strenuous
39. How do you spend your spare time (hobbies, etc)? \_\_\_\_\_
40. Do you use:  Caffeine? Drinks per day? \_\_\_\_\_  
 Tobacco?  
 Nicotine?  
 Recreational Drugs?  
 Alcohol? Drinks per week? \_\_\_\_\_
41. Please describe your work:  
 Type:  Professional  Physical Labor  Driver  Clerical  Factory  Homemaker  
 Physical Demands:  Heavy  Moderate  Mild  Sedentary  
 Stress Level:  High  Medium  Low

What Percentage of Time During the Day (at Home or at Your Job Away from Home) Do You Spend:  
 Sitting, \_\_\_\_\_%  Bending, \_\_\_\_\_%  Lifting, \_\_\_\_\_%  Working at a Computer, \_\_\_\_\_%

### Family History

42. Are there any diseases or conditions that are common among your family members (i.e., inherited diseases or conditions)?  No  Yes, \_\_\_\_\_

