



WholeCare

## Comprehensive Personal History

### Personal Information

Name \_\_\_\_\_ Name I Prefer To Be Called \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Soc. Sec. No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Occupation \_\_\_\_\_

E-Mail Address (WholeCare Updates Only!) \_\_\_\_\_

Relationship Status \_\_\_\_\_ Number & Ages of Children (If any): \_\_\_\_\_

For Women: No. of Pregnancies: \_\_\_\_\_ Date of Last Menstrual Period: \_\_\_\_\_

Are You Pregnant Now? Yes  No  Are You Nursing Now? Yes  No

Height: \_\_\_\_\_ Weight \_\_\_\_\_

How Did You Hear About WholeCare? \_\_\_\_\_

### Chief Health Concern

What Is Your Major Concern? \_\_\_\_\_

\_\_\_\_\_

Other Concerns: \_\_\_\_\_

How Long Have You Had This Condition? \_\_\_\_\_

Have You Had this Condition in the Past? \_\_\_\_\_

What Activities Aggravate Your Condition? \_\_\_\_\_

What Seems To Make It Better? \_\_\_\_\_

Is This Condition Progressively Getting Worse? Yes  No  Constant  Comes and Goes  Improving

Is This Condition Interfering With Your: Work  Sleep  Daily Routine  Enjoyment of Life

How Long Has It Been Since You *Really Felt Good*: \_\_\_\_\_

List Previous Diagnoses and Treatments You Have Received For Present Condition: \_\_\_\_\_

\_\_\_\_\_

What Do You Believe Is Wrong With You? \_\_\_\_\_

\_\_\_\_\_

## **Family Health Information**

Relation:

Past and Present Health Problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Personal History**

Have You Received Chiropractic Spinal Adjustments By A Doctor Of Chiropractic? \_\_\_\_\_

If Yes, When Was Your Last Visit? \_\_\_\_\_

Have You Used Or Do You Utilize Any Of The Following Modalities? If Yes, Please Explain When and Any Comments You Wish To Share:

Bodywork (Massage, Craniosacral, etc.): \_\_\_\_\_

Acupuncture: \_\_\_\_\_ Movement or Exercise/Yoga: \_\_\_\_\_

Rebirthing/Breathwork: \_\_\_\_\_ Meditation: \_\_\_\_\_

Prayer: \_\_\_\_\_ Psychotherapy: \_\_\_\_\_

Naturopathic Care: \_\_\_\_\_

Other/Comments: \_\_\_\_\_

Current Vitamins/Minerals/Herbs/Homeopathics (Please List): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What Do You Hope To Receive From Treatment at WholeCare: \_\_\_\_\_

\_\_\_\_\_

Describe Any Traumas Or Complications Associated With Your Birth: \_\_\_\_\_

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Have You (Even As A Passenger, Even If You Do Not Think You Were Hurt) Been Involved In A Vehicular Collision or Near Collision? Yes  No

Please List Approximate Dates and Severity (Mild, Moderate or Extreme): \_\_\_\_\_

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Were You Ever Knocked Unconscious? Yes  No

Have You Ever Used Crutches, A Walker, Or A Cane? Yes  No

Have You Ever Broken Any Bones? Yes  No

Have You Ever Had Any Impacts or Falls That You Feel May Have Injured Your Spine? Yes  No

If You Answered "Yes" To Any of the Above, Please Explain: \_\_\_\_\_

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During the Day I:

Sit  Stand  Walk  Desk Work  Phone Work  Drive  Mechanical Work  Heavy Lifting

Do You Consider Yourself:  Sedentary

Lightly Active (Sporadic Workouts, Lawn Work, Little Aerobic Work)

Moderately Active (Workout 1 -2 Days Per Week For At Least 15-30 Min)

Highly Active (Workout 3+ Days Per Week For At Least 30-45 Min)

Check If You Currently Have Or Have Previously Had Any Of The Following Conditions:

Acid Reflux

Diabetes

Hepatitis

Mumps

Alcoholism

Eczema

HIV/AIDS

Petrussis

Allergies

Emphysema

IBS

Pneumonia

Anemia

Endometriosis

Infertility

Polio

Arteriosclerosis

Epilepsy

Kidney/Bladder Infect.

Rheumatoid Arthritis

Arthritis

Fainting

Measles

Scarlet Fever

Cancer

Fever

Migraines

Stroke

Candida Infection

Gout

Miscarriage

Thyroid Problems

Depression

Heart Disease

Multiple Sclerosis

Tuberculosis

Urinary Tract Infection

Ulcers

Weight Gain/Loss

Venereal Disease

Other Conditions: \_\_\_\_\_

Do You Have A Particular Position For Sleeping?  No  Yes: \_\_\_\_\_

I Wear: Glasses  Bifocals  Contact Lenses

## **Medical Treatment**

Please List Any Drugs You Are Currently Taking Regularly (Prescription or Over-The-Counter):  
Use Other Side of Page If Necessary

Name of Drug	Reason for Use	For How Long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do You Work with Chemicals, Fumes, Dust, Powder and/or Smoke for Prolonged Periods? Please Explain:

\_\_\_\_\_

\_\_\_\_\_

Have You Ever Been Hospitalized or Undergone Surgery? Yes  No  If Yes, What Was Done To You?

\_\_\_\_\_

\_\_\_\_\_

Have You Had: Spinal Tap  Spinal Injections  Physiotherapy  Neck Collar  Spinal Brace  Traction   
Heel Lift  X-Ray Treatments  Corrective Shoes  Corrective Braces  Chemotherapy   
Extensive Diagnostic X-Rays  Mammogram  Endoscopy  Transfusion   
Breast Augmentation  Colonoscopy  Bone In A Cast Or Immobilization

Results: \_\_\_\_\_

\_\_\_\_\_

## **Self Assessment**

How Do You Grade Your Physical Health? Excellent  Good  Fair  Poor  Improving  Worsening

How Do You Grade Your Emotional/Mental Health? Excellent  Good  Fair  Poor  Improving  Worsening

Please Rate Your Current Stress Level From 1 – 10  
(low) 1 2 3 4 5 6 7 8 9 10 (high)

What Hours Do You Generally Sleep? \_\_\_\_\_

Nap in the Daytime? Yes  No

Do You Have Trouble Falling Asleep? Yes  No

Do You Have Trouble Staying Asleep? Yes  No  List Any Sleep Aids You Use: \_\_\_\_\_

Do You Wake Feeling Rested? Yes  No

Please Rate Your Energy Level From 1 – 10  
(low) 1 2 3 4 5 6 7 8 9 10 (high)

Do You Have An Energy Dip In The Afternoon? Yes  No

How Much Water Do You Drink Each Day? \_\_\_\_\_

What Kind of Water Do You Drink? \_\_\_\_\_

How Many Cups of Coffee Do You Drink Daily? \_\_\_\_\_ Decaf? Yes  No

How Many Cups of Tea Do You Drink Daily? \_\_\_\_\_ Type of Tea? \_\_\_\_\_

How Many Soft Drinks Do You Drink Daily? \_\_\_\_\_

How Many Glasses of Alcohol Do You Drink Daily? \_\_\_\_\_

How Many Ounces of Juice Do You Drink Daily? \_\_\_\_\_

How Would You Describe Your Diet?

- Vegetarian
- Vegan
- Raw Food
- Low Carb
- Low Fat
- Other (describe) \_\_\_\_\_

Please Describe Any Food Cravings You Have (For **specific** foods such as bread or chocolate, or **types** of food such as salty, crunchy, etc.) \_\_\_\_\_

Please List Any Foods That You Know Negatively Affect You In Any Way \_\_\_\_\_

How Often Do You Have a Bowel Movement? \_\_\_\_\_

Do You Have To Use Anything To Make Your Bowels Move?  No  Yes \_\_\_\_\_

Are Your Stools Easy To Pass? Yes  No

Are Your Stools Ever: Very Light Brown  Yellowish  Greenish  Putty Colored

Do You Ever Have Discomfort Under Your Ribs on the Right Side (Especially After Eating a High Fat Meal)?  
Yes  No

Have You Ever Noticed Bubbles In Your Urine That Don't Disappear Immediately? Yes  No

I Have At Least One Family Member Within 50 Miles on Whom I Can Rely. Always  Sometimes  Never

I Have a Network of Friends and Acquaintances. Always  Sometimes  Never

I Have One or More Friends to Confide in About Personal Matters. Always  Sometimes  Never

I Get Strength From My Religious or Spiritual Traditions and/or Beliefs. Always  Sometimes  Never

If You Consider Yourself Ill, Why Do You Feel You Are Ill? \_\_\_\_\_

\_\_\_\_\_

If You Consider Yourself Well, Why Do You Feel You Are Well? \_\_\_\_\_

\_\_\_\_\_

Is There Anything Else You Wish To Share That May Help To Better Understand You? \_\_\_\_\_

\_\_\_\_\_

### **Authorization for Treatment**

#### **For All Patients**

I hereby authorize WholeCare to treat my condition as deemed appropriate through the use of chiropractic manipulation, nutritional therapy, physiotherapy and/or other natural, drug-free methods.

I choose to be an active participant in my treatment and realize that I am responsible for my health choices.

I understand and agree that I am responsible for payment of WholeCare services at the time of my visit ***unless*** prior arrangements have been made.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Or, If Appropriate, Parent / Guardian Signature \_\_\_\_\_

Parent / Guardian Name (Please Print) \_\_\_\_\_ Date: \_\_\_\_\_

#### **For Naturopathic Patients**

In engaging in a consultation with Gina Perry, N.D., I fully understand that Gina Perry is not a medical doctor or practitioner and I am not here for medical or diagnostic purposes or treatment procedures. The services performed by Gina Perry of WholeCare are at all times restricted to consultation on the subject of nutritional and lifestyle habits. I understand that Jack Armstrong, D.C. of WholeCare is the supervising and treating physician.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Or, If Appropriate, Parent / Guardian Signature \_\_\_\_\_

Parent / Guardian Name (Please Print) \_\_\_\_\_ Date: \_\_\_\_\_