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 _____ Occupation _____

E-Mail Address (Whole*Care* 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 Whole*Care*? _____

Chief Health Concern

What Is Your Major Concern? _____
_____
_____
_____
_____

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? _____
_____

Other Concerns: 1._____
How long? _____

Other Concerns: 2._____
How long? _____

Other Concerns: 3._____
How long? _____

Other Concerns: 4._____
How long? _____

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 Whole*Care*: _____
_____

Describe Any Traumas Or Complications Associated With Your Birth: _____
_____

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):_____
_____

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: _____
_____
_____

What Is Your Occupation? _____

Do You Enjoy Your Work? Yes □ No □ Sometimes □

How Many Hours Each Day Do You Work? _____

At What Times Do You Start And End Work? _____

Do You Smoke? Yes □ No □ If Yes, How Much And For How Long? _____

If No, Does Anyone In Your Household Or Workplace Smoke? Yes □ No □

Do You Wish To Gain Weight? _____ Lose Weight? _____ How Much? _____

How Many Hours Do You Spend Daily, On Average?
Driving_____ Watching TV_____ Reading_____ In Front Of A Computer_____

What Are Your Interests And Hobbies?
_____
_____

Do You Vacation Regularly? Yes □ No □

When Was Your Last Vacation? _____

Do You Actively Participate In Any Spiritual Discipline? (Church, Religious Group, Meditation, etc.) Yes □ No □

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 □ Alcoholism □ Allergies □ Anemia □ Arteriosclerosis □

Cancer □	Candida Infection □	Depression □	Diabetes □	Eczema □
Emphysema □	Endometriosis □	Epilepsy □	Fainting □	Fever □
Gout □	Heart Disease □	Hepatitis □	HIV/AIDS □	IBS □
Infertility □	Kidney/Bladder Infections □	Measles □	Mercury Fillings □	Migraines □
Miscarriage □	Multiple Sclerosis □	Mumps □	Pertussis □	Pneumonia □
Polio □	Rheumatoid Arthritis □	Scarlet Fever □	Stroke □	Thyroid Issues □
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 □	Mammogram □
	Extensive Diag. X-Rays □	Endoscopy □	Transfusion □	Breast Augmentation □
	Colonoscopy □	Bone In 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 □ Paleo □
Other (describe) _____

Please Indicate How Many Cups Of The Following You Drink Per Day:

_____Bottled/Spring Water	_____Tap Water	_____Milk (1% or 2%)	_____ Milk (skim)
_____Fresh Vegetable Juices	_____Fresh Fruit Juices	_____ Fruit Juices (prepared)	
_____Red Wine	_____White Wine	_____ Beer	_____ Herbal Tea
_____ Tea	_____ Soft Drinks (diet)	_____ Soft Drinks (regular)	
_____ Coffee	_____ Other alcoholic	_____ Other (specify)_____	

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

Do You Avoid Certain Foods? If so, why? _____
_____

How Often Do You Have a Bowel Movement? _____

Do You Have To Use Anything To Make Your Bowels Move? Yes □ No □_____

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 (Esp. After Eating a High Fat Meal)?Yes □ No □

What Level Of Stress Do You Feel You Are Experiencing At This Time?
Minimal □ Average □ Considerable □ Unbearable □

What Are The Major Causes Or Factors Of Your Stress? (Check All That Apply)

_____Financial	_____Career	_____Personal	_____Marriage
_____Health	_____Family	_____Spiritual	_____Unfulfilled Expectations

How Does Your Stress Manifest Itself? _____
_____
_____

Do You Use Any Coping Mechanisms, i.e. Meditation, Exercise, Drugs, Alcohol, etc.? _____
_____

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 Whole*Care* 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 Whole*Care* 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: _____