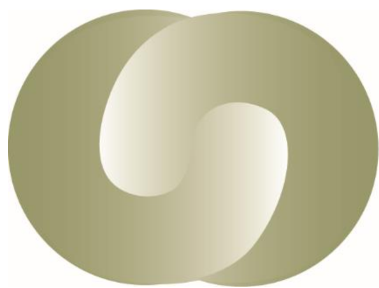

Comprehensive Personal History

Personal Information

Date ___________________

Name _________________________________ Name I Prefer To Be Called ____________________________

Date of Birth ___________________________ Occupation ____

Address ____________________________________ City ___________________ State _______ Zip ___________

Preferred Method of Contact:

Mobile Phone ______-______-_______ Home ______-______-_______ Other ______-______-_______

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: ____

I Wear (please circle): Glasses Bifocals Contact Lenses

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: ____

____

____

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

Please List Approximate Dates and Severity: Mild Moderate 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: ____

____

____

____

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)

During the Day I:

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

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

Acid Reflux	Endometriosis	Migraines
Diabetes	Infertility	Stroke
Hepatitis	Polio	Candida Infection
Mumps	Arteriosclerosis	Gout
Alcoholism	Epilepsy	Miscarriage
Eczema	Kidney/Bladder Infect.	Thyroid Problems
HIV/AIDS	Rheumatoid Arthritis	Depression
Pertussis	Arthritis	Heart Disease
Allergies	Fainting	Multiple Sclerosis
Emphysema	Measles	Tuberculosis
IBS	Scarlet Fever	Urinary Tract Infection
Pneumonia	Cancer	Ulcers
Anemia	Fever	Weight Gain/Loss
		Venereal Disease

Other Conditions: ____

____

____

Do You Have A Particular Position For Sleeping? No Yes ______________________________

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 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? 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 (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

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: ___________________