

HealthWise Family Chiropractic: Acupuncture Patient Health History



3803 Silver Lake Road Unit 100 • St Anthony MN, 55421
Phone: 612-789-1700 Fax: 612-788-9011

Today's Date _____

Name _____ Birthdate/Age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Occupation _____ Employed by: _____

Work Address _____ Work Phone _____

Email Address _____

Is it ok to contact you by (please circle): All Email Cell Home Work

Marital Status: S M W D Number of Children _____

Emergency Contact: _____ Phone Number: _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to HealthWise Family Chiropractic for Acupuncture

in order of importance below:

Condition

Past Treatment

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you? _____

c. _____

How does this condition affect you? _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to
(please include reaction) _____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently
taking _____

6. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. Family History: (Check those applicable)

<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
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Age (if living)					
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_____	_____	_____	_____	_____	_____
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Health (G=Good, P=Poor)					
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_____	_____	_____	_____	_____	_____
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Cancer					
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_____	_____	_____	_____	_____	_____
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Diabetes					
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_____	_____	_____	_____	_____	_____
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Heart Disease					
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_____	_____	_____	_____	_____	_____
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High Blood Pressure					
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_____	_____	_____	_____	_____	_____
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Stroke					
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_____	_____	_____	_____	_____	_____
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Mental Illness

Asthma/Hay fever/Hives

Kidney Disease

Age (at death)

Cause of Death

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____

When was this reading taken? _____

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

13. **Hospitalizations and Surgeries:**

Reason When Reason When

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the

past): Mood Swings Nervousness Mental Tension Depression

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have

experienced in the past): Fatigue Slow Wound Healing Chronic Infections
Easy Bruising Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat**

(please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts
Tearing/Dryness Impaired Hearing Ear Ringing Earaches Headaches
Sinus Problems Nose Bleeds Frequent Sore Throats Teeth Grinding
TMJ/Jaw Problems Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the

past): Pneumonia Frequent Common Colds Difficulty Breathing Emphysema
Persistent Cough Pleurisy Asthma Tuberculosis Shortness of Breath Other Respiratory
Problems: _____

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in

the past): Heart Disease Chest Pain Swelling of Ankles High Blood Pressure
Stroke Palpitations/Fluttering Heart Murmurs Rheumatic Fever Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced

in the past): Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain
Passing Gas Heartburn Belching Gall Bladder Disease Liver Disease
Hepatitis B or C Hemorrhoids Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have

experienced in the past): Kidney Disease Painful Urination Frequent UTI
Frequent Urination Heavy Flow Kidney Stones Impaired Urination
Blood in Urine Frequent Urination at Night

22. **Female Reproductive/Breasts**(please circle any that you experience now and underline any that you

have experienced in the past) Irregular Cycles Breast Lumps/Tenderness
Nipple Discharge Heavy Flow Vaginal Discharge Premenstrual Problems Clotting/Bleeding
Between Cycles Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 2. # of Days of Menses: _____ 3. Length of Cycle: _____
4. Birth Control Type: _____ 5. # of Pregnancies: _____ 6. # of Miscarriages: _____
7. # of Abortions: _____ 8. # of Live Births: _____

24. **Male Reproductive** (please circle any that you experience now and underline any that you have

experienced in the past): Sexual Difficulties Prostrate Problems
Testicular Pain/Swelling Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past): Neck/Shoulder Pain Muscle Spasms/Cramps

Arm Pain Leg Pain Upper Back Pain Mid Back Pain Low Back Pain

Joint Pain (if so, where?): _____

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past): Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past): Hypothyroid Hypoglycemia Hyperthyroid

Diabetes Mellitus Night Sweats Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past): Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

29. **Lifestyle:**

How many meals do you typically eat per day? _____

Exercise routine: _____

Spiritual practice: _____

How many hours per night do you sleep? _____ Do you wake rested? Y N

Level of education completed: High School Bachelors Masters Doctorate Other

Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

Nicotine/Alcohol/Caffeine Use: _____

Have you experienced any major traumas? Y N

Explain: _____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Television habits: _____

Reading habits: _____

Interests and hobbies: _____

How did you hear about us?

Would you like to receive our email newsletter?



Acupuncture Cancellation Policy

At least a 24-hour notice of cancellation is required if you need to cancel your scheduled appointment. Cancellation less than 24 hours in advance results in a cancellation fee of the full price of the acupuncture session.

This policy was instituted for the benefit of both patients and practitioners. We appreciate your cooperation in this manner. We look forward to serving you in the future.

I have read and understood the above information.

Patient Signature

Date