

## Om Spa Chiropractic & Wellness Patient Health History

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(first) (middle) (last)

Street: \_\_\_\_\_ Height: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Weight: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Emerg. Name & # \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M/F Occupation: \_\_\_\_\_

Who is your Physician? \_\_\_\_\_ Physician's Phone # \_\_\_\_\_

Other Concurrent Therapies: \_\_\_\_\_

*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. Please identify the health concerns that have brought you to Om Spa Chiropractic & Wellness 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? \_\_\_\_\_

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

\_\_\_\_\_

3. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking or have taken within last 2 months: \_\_\_\_\_

\_\_\_\_\_

**4. Family History: (check those applicable)**

Cancer _____	Seizure _____	Kidney Disease _____
Diabetes _____	TB _____	Scoliosis _____
Heart Disease _____	Ulcers _____	Glaucoma _____
High Blood Pressure _____	Osteoarthritis _____	Alcoholism _____
Stroke _____	Rheumatoid Arthritis _____	Drug Problem _____
Asthma/Hay Fever/Hives _____	Mental Illness _____	Other _____

**5. Your Past Medical History** (please circle any that you have had):

AIDs/HIV	Cancer	Gout	Multiple Sclerosis	Rheumatic Fever	
Alcoholism	Chicken Pox	Heart Disease	Mumps	Scarlet Fever	Ulcers
Allergies	Diabetes	Hepatitis	Pacemaker	Seizures	Venereal Disease
Appendicitis	Emphysema	Herpes	Pleurisy	Stroke	Whooping Cough
Arteriosclerosis	Epilepsy	High Blood Pressure	Pneumonia	Thyroid Disorders	Other: _____
Asthma	Goiter	Measles	Polio	Tuberculosis	

**6. Hospitalizations and Surgeries:**

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

**7. General Symptoms** (please *circle* any that you experience now and *underline* any that you have experienced in the past):

Poor Appetite	Fatigue	Cold Abdomen	Chronic Infections
Heavy Appetite	Tremors	Fevers	Localized Weakness
Poor Sleep	Vertigo	Chills	Poor Coordination
Heavy Sleep	Colds Hands or Feet	Night Sweats	Change in Appetite
Insomnia	Cold Back	Sweats Easily	Strong Thirst
Bleed/Buise Easily	Peculiar Taste/Smell	Cravings	Sudden Energy Drop at _____ time

**8. Head, Eye, Ear, Nose, and Throat** (please *circle* any that you experience now and *underline* any that you have experienced in the past):

Headaches	Blurry Vision	Color Blindness	Mucus	Teeth Grinding
Migraines	Spots in Eyes	Cataracts/Glaucoma	Nose Bleeds	Teeth Problems
Dizziness	Eye Pain/Strain	Tearing/Dryness	Frequent Sore Throats	Dry Throat
Concussions	Poor Vision	Earaches	Lips/Tongue Sores	Dry Mouth
Facial Pain	Night Blindness	Ringing in Ears	TMJ/Jaw Problems	Copious Saliva
Sinus Problems	Glasses/Contacts	Poor Hearing	Gum Problems	Hay Fever

**9. 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: _____		

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

High Blood Pressure	Low Blood Pressure	Fainting	Irregular Heartbeat	Stroke
Heart Disease	Varicose Veins	Swelling of Ankles	Difficulty Breathing	Chest Pain
Palpitations/Fluttering	Cold Hands/Feet	Heart Murmurs	Rheumatic Fever	Blood Clots

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

Bad Breath	Constipation	Pain or Cramps	Rectal Pain	Bloody Stools	Diarrhea
Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Passing Gas	Heartburn
Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C	Hemorrhoids	Abdominal Pain

12. **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	
Urgency to Urinate	Unable to Hold Urine			

13. **Female Reproductive** (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
Menopause	Difficulty Conceiving	Painful Periods	Vaginal Sores

14. **Menstrual/Birthing History:**

Age of First Menses: _____	Birth Control Type: _____	# of Miscarriages: _____
# of Days of Menses: _____	# of Pregnancies: _____	# of Abortions: _____
Length of Cycle: _____	# of Live Births: _____	# of Premature Births: _____

15. **Male Reproductive** (please *circle* any that you experience now and *underline* any that you have experienced in the past):

Sexual Difficulties	Prostate Problems	Testicular Pain/Swelling	Penile Discharge
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16. **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	Upper Back Pain	Mid Back Pain
Low Back Pain	Leg Pain	Joint Pain (if so, where?): _____		

17. **Skin and Hair** (please *circle* any that you experience now and *underline* any that you have experienced in the past):

Rashes	Pimples	Ulcerations	Dandruff	Hives	Loss of Hair
Itching	Purpura	Eczema	Psoriasis	Changes in Hair/Skin Texture	
Other Hair/Skin Problems _____					

18. **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

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

Seizures    Numbness/Tingling    Poor Memory    Concussion    Depression    Anxiety  
Vertigo    Dizziness    Loss of Balance    Tics    Bad Temper    Easily Stressed  
Paralysis    Seeing a Therapist    Considered/Attempted Suicide

Other Neurological or Psychological problems: \_\_\_\_\_

20. **Diet** (please *circle* those applicable):

Low Appetite    Coffee    Sugar    Salty Foods  
Heavy Appetite    Soft Drinks    Artificial Sweetener    Greasy/Fried Foods

**Please Describe Your Average Daily Diet below:**

<b>Morning</b>	<b>Afternoon</b>	<b>Evening</b>	<b>Snacks</b>
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21. **Lifestyle:** (please *circle* those applicable):

Alcohol    Tobacco    Marijuana    Drugs    Stress

Frequency of Use: \_\_\_\_\_

Occupations Stresses (chemical, physical, psychological, etc.): \_\_\_\_\_

Regular Exercise: (type) \_\_\_\_\_ (frequency) \_\_\_\_\_

(type) \_\_\_\_\_ (frequency) \_\_\_\_\_

Have you experienced any major traumas?    Y    N    Explain: \_\_\_\_\_

\_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_