Initial Health History Form

Name: _____ Date: _____

Address: _____ Phone: _____

Medical Doctor: _____ Previous Chiropractor: _____

Global Wellness Clinic's objective is different from an Allopath's (M.D./ D.O.) objective. Our objective is not to just identify and treat a condition, rather but additionally identify and correct subluxations.

If you have no condition and are seeking chiropractic care to optimize body function and performance, skip to Section II.

Section I

Present complaint (brief) _____
Date started _____
Do you know what may have started it? _____
What aggravates condition/pain? _____
What lessens condition/pain? _____
Is condition worse during certain times of day? _____
Is condition interfering with work? _____
Is condition getting progressively better, worse, no change? _____
Has this problem interrupted your sleep? □ Yes □ No How? _____
Have you seen a doctor for this condition? _____ When? _____
What tests did you have? _____
What diagnosis did they give? _____
What treatment did you receive? _____

Difficulty with:	□ Standing	□ Sitting	□ Bending	□ Walking	□ Lying	□ Other
Cannot lift:	□ Light	□ Moderate	□ Heavy	□ Repetitive		
Have experienced:	□ Dizziness □ Fainting □ Headaches	□ Unsteadiness □ Pins and Needles	□ Shortness of Breath □ Bowel/Bladder Difficulty		□Chest Pain □Double Vision	

Please list 1 activity you are unable to perform or having the most difficulty with because of your chief problem.

1. _____

(In your visits here we want to know what one activity in your life you are unable to do or having the most difficulty with as a result of your chief problem.)

OVER →

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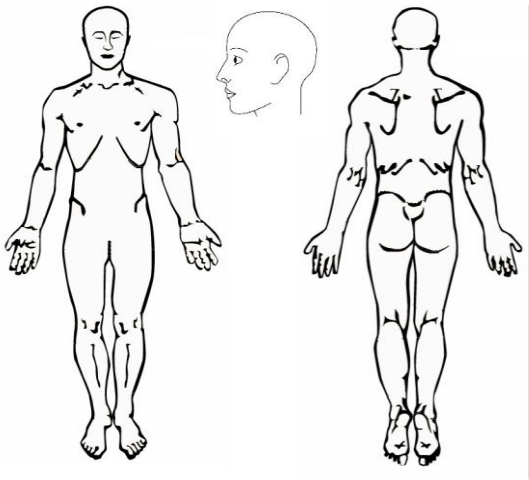
Aches: ΛΛΛΛ Numbness: oooo Pins/Needles: ●●●● Burning: XXXX Stabbing: ////

Please be extremely accurate when filling out this form. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of pain that travel and include all affected areas. You may draw on the face as well.



Is Your Discomfort:

Sharp ___

Dull ___

Constant ___

On & Off ___

Please rate your discomfort below by indicating where your condition is at **now** with a circle.

1 2 3 4 5 6 7 8 9 10

_____

None **Most Severe**

Section II

Did/Do you smoke? _____ Do you drink pop? _____
Do you wear Orthotics? □ Yes □ No Past auto accidents? _____
Injuries? _____
Fractures (broken bones) ? _____
Teeth, eyes, or hearing problems? _____
Do you have occupational stress? _____ Do you have physical stress? _____
Do you have mental stress? _____
Surgeries (Please list all) _____
Current Medications _____
Past medical history _____
Allergies _____

Family History	*Heart*	*Arthritis*	*Cancer*	*Diabetes*	*Other*
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____

Social History: _____

To the best of my knowledge, all statements in the above Health History are true.
Signed _____ Date _____
(If patient is under 18 years, parent must sign)