ADVANCED WELLNESS CENTER

PERSONAL HISTORY

Full Name: _____ Today's Date: _____ E-Mail: _____

D.O.B.: _____ Age: _____ Sex: ___ M ____ F Cell Phone: _____

LOCAL Address: _____ Home Phone: _____

City, State: _____ Zip: _____ Work Phone: _____

Out-of-Town Address: _____

Type of Work: _____ Name of Spouse: _____

Number of Children (if any): _____ Check One: ___ Child ___ Single ___ Married ___ Widowed

If applicable, name of person here in the office with you today: _____

Emergency Contact Name & Cell Phone: _____

How were you referred you to our office?: __ Individual (Name please:)_____

___ facebook ___ Google review ___ Internet search ___ Other (Please specify): _____

CURRENT HEALTH CONDITION

Please prioritize your PRIMARY HEALTH CONCERNS: _____

Health Care Professionals seen for this condition:_____

Family members with this condition: _____

Remember to <u>BRING</u> medication and supplement BOTTLES you may be taking for testing!

PRESCRIPTIONS you regularly take: _____

SUPPLEMENT(S) you regularly take: _____

_____

ALLERGIES: Foods or substances which aggravate your condition or to which you are allergic:

_____

DIET: Please indicate the diet you follow: ___ Vegan ___ Vegetarian ___ Organic ___ Caribbean Diet

__ Standard American Diet Other: _____

PREVIOUS HEALTH HISTORY

Please indicate any Diagnosis (Diabetes, etc.) organs removed, surgeries/dates, hospitalizations or treatments (radiation, physical therapy, etc.)_____

_____

_____

MAJOR ACCIDENTS OR FALLS & THEIR DATES: _____

Previous Chiropractor's name & last date of visit:_____

PLEASE PLACE A (√) CHECK MARK IF YOU'VE HAD ANY OF THE FOLLOWING DISEASES:

___ Chicken Pox
___ Influenza
___ Measles
___ Mumps
___ Pleurisy
___ Pneumonia
___ Polio
___ Rheumatic Fever
___ Small Pox
___ Thyroid Condition: Type: _____
____ Tuberculosis
____ Whooping Cough
____ Anemia
____ Arthritis
____ Cancer: Where?
____ Diabetes
____ Epilepsy
____ Heart Disease
____ Mental Condition

MERCURY TOXINS

Mercury Dental Fillings: ____

TATTOO ON BODY?

____ No ___ Yes

If yes, where? _____

BREAST IMPLANTS?

___ No ___ Yes

CHECK IF YOU CONSUME:

___ Coffee ___ Tea ___ Soda
___ Alcohol ___ White Sugar
___ Dairy ___ Cigarettes

VACCINATIONS

Childhood Vaccinations?

____ No ____ Yes

COVID-19 Vaccination?

____ No ____ Yes

If yes, When? _____

Which? ____ Pfizer
____ Moderna
____ J & J

Booster?

____ No ____ Yes

If yes, When? _____

PLEASE PLACE A (√)CHECK MARK IF YOU'VE HAD ANY OF THE FOLLOWING IN THE LAST 6 MONTHS.

MUSCULOSKELETAL

___ Low Back Pain
___ Pain Between Shoulders
___ Neck Pain
___ Arm Pain
___ Joint Pain/Stiffness
___ Walking Problems
___ Difficulty Chewing
___ Pain / Clicking Jaw
___ General Stiffness

GENITO-URINARY

___ Bladder/Urinary
___ Painful/Excessive Urination
___ Discolored Urine

GASTRO-INTESTINAL

___ Poor/Excessive Appetite

GASTRO-INTESTINAL

___ Excessive Thirst
___ Vomiting
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Liver Problems
___ Gall Bladder Issues
___ Weight Trouble
___ Abdominal Cramps
___ Gas/Bloating After Meals
___ Heartburn
___ Black/ Bloody Stool
___ Colitis

How often do you move your bowels? _____

NERVOUS SYSTEM

___ Nervous
___ Numbness
___ Paralysis
___ Dizziness
___ Forgetfulness
___ Confusion/ Depression
___ Fainting
___ Convulsions
___ Cold/Tingling
___ Extremities
___ Stress

CARDIO-VASCULAR/ RESPIRATORY

___ Chest Pain
___ Shortness of Breath
___ Blood Pressure Prob.
___ Irregular Heart Beat
___ Lung Problems/ Congestion
___ Varicose Veins
___ Ankle Swelling
___ Stroke
___ Heart Attack
___ Heart Valve Issues

Do you have a pacemaker?

Yes ◯ No ◯

FEMALE:

Length of Menses: _____ to _____
Days ◯ Weeks ◯ Months ◯

Time Between Menses: _____ to _____
Days ◯ Weeks ◯ Months ◯

___ Menstrual Irregularity
___ Menstrual Cramping
___ Clotting during Menses
___ Heavy flow during Menses
___ Vaginal Pain / Infections
___ Hot Flashes
___ Breast Pain / Lumps
___ Sexual Dysfunction

Are you pregnant? ◯ Yes ◯ No

When was your last period? _____

MALE:

___Sexual Dysfunction ____ Frequent Urination

GENERAL

___Fatigue
___ Allergies
___ Loss of Sleep
___ Fever
___ Headaches

EAR, EYES, NOSE and THROAT

___ Vision Problems
___ Dental Problems
___ Sore Throat
___ Ear Aches
___ Hearing Difficulty
___ Stuffed Nose

Please Mark Areas of Discomfort