Welcome to Way of Life Wellness Center

Personal Health History

Name _____ **Date** _____

Address _____ **City/State/Zip** _____

Phone (cell) _____ **(h/w)** _____ **email** _____

DOB _____ **Age** _____ **Occupation** _____ **Marital Status** _____

Spouse's name _____ **No. of Children** _____

Do you wish to use insurance? ☐ **Yes** ☐ **No** **If yes, please supply SS#** _____

Who can we thank for referring you to our office? _____

Reason you seek Network Chiropractic Care? _____

When did this situation or concern begin? _____

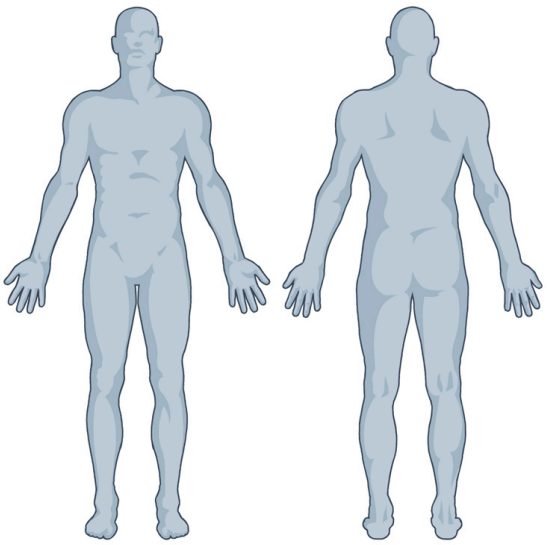
Please Circle Areas of Health Concern

Have you done anything about this situation or concern,
or gotten any advice or treatment? ☐ Yes ☐ No

What were you told? _____

What was done? _____

Did it seem to work? _____



Does this health concern affect your:

☐ recreation/play ☐ social life ☐ exercise ☐ work ☐ rest/sleep ☐ walking ☐ sitting ☐ love life

Is there any time, or activity you can be involved with when you forget about this condition or symptom?

_____

Is there any time of day or activity which makes you more aware of it? _____

Why do you think this has happened or continues to happen to you? _____

Do you think this is the sole cause? ☐ Yes ☐ No

If no, what else is involved? _____

If this condition or symptom were to go away tomorrow, what would be different about your life?

_____

What are you doing in your life now that is different than if you did not have this condition?

_____

Do you have any other health concerns? _____

Do you, or have you in the past, participated in any of the following healing modalities? If yes, feel free to comment.

☐ Chiropractic _____ Who? _____
☐ Bodywork/Massage _____ ☐ Psychotherapy _____
☐ Naturopathy _____ ☐ Acupuncture _____
☐ Yoga/Tai Chi/Qi Gong _____ ☐ Meditation _____

The following questions focus on the types of stress you have encountered during your lifetime. These stresses may have affected your nervous system and spinal structure and lead to the present condition of your spine.

PHYSICAL STRESSES

Your birth process was: ☐ home ☐ hospital ☐ breech ☐ suction or forceps ☐ C-section ☐drug induced

Did you have any childhood illnesses or injuries? _____

Have you experienced any traumatic injuries such as:

Car/Bike accidents _____
Knocked unconscious _____
Broken bones/Major Sprains _____
Sports injuries _____
Major falls or impacts _____
Other physical traumas _____

Rate your **present** Physical Stress Level 0 1 2 3 4 5

Rate you **past** Physical Stress Level 0 1 2 3 4 5

0 - no awareness of stress,
5 - extreme stress

During the day you: ☐ sit ☐ stand ☐ walk ☐ desk work ☐ phone work ☐ drive ☐ heavy lifting

Have you ever had any of the following diseases or medical problems?

☐ Anemia	☐ Dizziness	☐ Menstrual Problems
☐ Asthma	☐ Arthritis	☐ Depression
☐ Cancer/Chemotherapy	☐ Diabetes/TB	☐ Difficulty Breathing
☐ Emphysema/Glaucoma	☐ Epilepsy/Seizures	☐ Herpes
☐ Heart Attack/Stroke	☐ Heart Surgery	☐ Hepatitis
☐ Abnormal Bleeding	☐ High/Low Blood Pressure	☐ HIV/AIDS
☐ Kidney Problems	☐ Psychiatric Conditions	☐ Fatigue
☐ Rheumatic/Scarlet Fever	☐ Headaches	☐ Sinus Problems
☐ Ulcers/Colitis	☐ Tingling/Numbness	☐ Allergies

Please list any serious medical problem(s) or surgery that you have ever had:

_____

_____

CHEMICAL STRESS

Are you currently taking any prescription or over the counter drugs? Please list drugs and reasons for taking them:

_____

If you were previously taking medication regularly, please describe:

_____

Do you or did you work with any chemical, fume, dust, powder or smoke for prolonged periods of time? ☐Y ☐N

Rate your **current** Chemical Stress Level	0	1	2	3	4	5	***0 - no awareness of stress, 5 - extreme stress***
Rate your **past** Chemical Stress Level	0	1	2	3	4	5	

LIFESTYLE

Exercise: frequency _____ type _____

Sleep: average # hours _____ quality _____

Tobacco: amount per day _____ in the past? _____

Caffeine: amount per day _____ in the past? _____

Alcohol: amount per week _____ in the past? _____

Recreational Drugs: amount _____ in the past? _____

Diet: ☐ excellent ☐ average ☐ needs improvement

Do you have an exercise, meditation, prayer, nutritional and/or dietary program that you follow?

Please describe: _____

When stressed, how do you "center yourself" or "re-group"? _____

EMOTIONAL STRESS

Please circle any of the following emotional stresses which you are currently experiencing or have experienced in the past. Put a **C** next to those that are **current stressors** for you.

Childhood	Work Related Stress	School Stress	Loss of Loved One
Stress of an Illness	Emotional/Physical/Sexual Abuse		Change of Lifestyle
Financial Stress	Personal Relationships	Family Stress	Change in Vocation/Job

Rate your **present** Mental/Emotional Stress	0	1	2	3	4	5	***0 - no awareness of stress, 5 - extreme stress***
Rate your **past** Mental/Emotional Stress	0	1	2	3	4	5	

Is there some aspect of your life that very much pleases you, brings you joy, or helps you to feel better about yourself? _____

Are there any particular elements to your life, experiences, family, work, recreation, past injuries, genetics, outlook etc. that you feel impair your opportunity for perfect health?

_____

Are there any particular factors about your life, experiences, family, work, recreation, dietary programs, exercises, outlook, etc. that you feel give you an edge, or add to your health?

_____

In a published study of over 2,800 patients in Network Care, conducted in the Medical College of the University of California, Irvine, patients reported an overall improvement in all of the categories of health and wellness listed below. How do you hope to benefit from care in this office?

Please rate 0-5 (0 - not important to me, 5 - very important to me)

0 1 2 3 4 5	Improvement of my physical symptoms.
0 1 2 3 4 5	Improvement of emotional/mental symptoms.
0 1 2 3 4 5	Improvement of my ability to handle stress.
0 1 2 3 4 5	Improvement in enjoyment of life and the ability to make constructive lifestyle choices.

Is there anything else you wish to share to help us better understand you?

_____

Thank you for choosing Way of Life Wellness Center. We are looking forward to helping you to be successful in your ability to develop a healthy spine and nervous system. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.