

Thank you for carefully answering each question!

Thank you for choosing our facility. In our clinic we carefully examine all of the systems in your body so that we may gather all the information necessary in order to best address your healthcare and wellness. Please bear with us and all the paperwork we present to you. Please do not assume that any question is irrelevant or unimportant to your case, everything we ask here is highly relevant and extremely important! We need you to carefully and honestly answer every question so that we may piece together the best approach to managing your case.

Check as many that apply to you about your reason for visiting us today:

<input type="checkbox"/> Wellness care:	If yes, please indicate which of the following you are interested in:	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Hormone testing
		<input type="checkbox"/> Genomic testing	<input type="checkbox"/> Spinal & joint health
		<input type="checkbox"/> Nutritional counseling	<input type="checkbox"/> Food allergy testing
		<input type="checkbox"/> Lifestyle management	<input type="checkbox"/> Neurological assessment
		<input type="checkbox"/> Neurotransmitter testing	<input type="checkbox"/> Other?
<input type="checkbox"/> Motor vehicle accident? When did it occur?		<input type="checkbox"/> Recent Fall? When did it occur?	
<input type="checkbox"/> Another type of accident, trauma, or injury:	If yes, please answer the following: Please explain what the incident was; was it at work, home, or somewhere else?	<input type="checkbox"/> Less than 3 days old	<input type="checkbox"/> Between 3 days & 8 wks
		<input type="checkbox"/> Between 8 wks & 4 months	<input type="checkbox"/> More than 4 months
<input type="checkbox"/> Neurological problem or disease:	If yes, please explain & include any prior diagnoses:		
<input type="checkbox"/> Diagnostics:	If yes, please explain what you think you are being treated and evaluated for:		

HxA-MVA
HxA-Fa

HxA-FN

Where you referred to us by another health care provider? No. Yes. If yes, who? _____

Are you currently taking any medications (prescribed or over the counter), if so please list them and include dosage? *(if more than 12 meds, please tell us & we will provide you with more paper!)*

- | | | |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____ |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

Are you currently taking any herbs or nutritional supplements, if so please list them? *(if more than 12, please tell us!)*

- | | | |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____ |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

Do you have any known allergies, if so please list them? *(if more than 6, please tell us!)*

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
|----------|----------|----------|

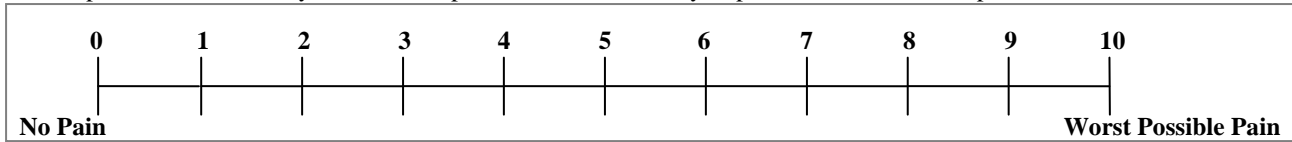
If you have a Primary Complaint, please answer the following:

Doctor's Notes: _____

Doctor's Initials: _____

What is your primary complaint? _____

Is there pain associated with your chief complaint? No. Yes. If yes, please mark where that pain is on a scale of 1-10?



Have you seen anyone else for this condition? No. Yes. If yes, who? _____

Have you lost work days for this condition? No. Yes. If yes, how much? _____

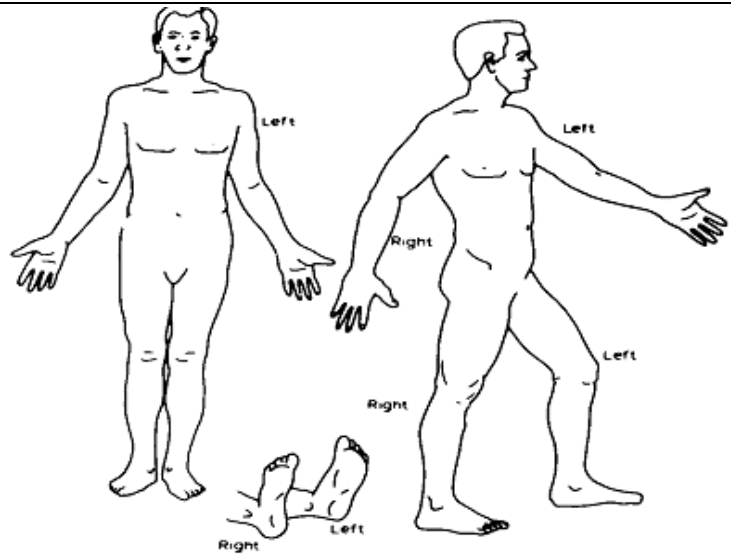
Have you tried any self-treatments for this condition? _____

Have you ever been treated for a similar problem, if so describe? _____

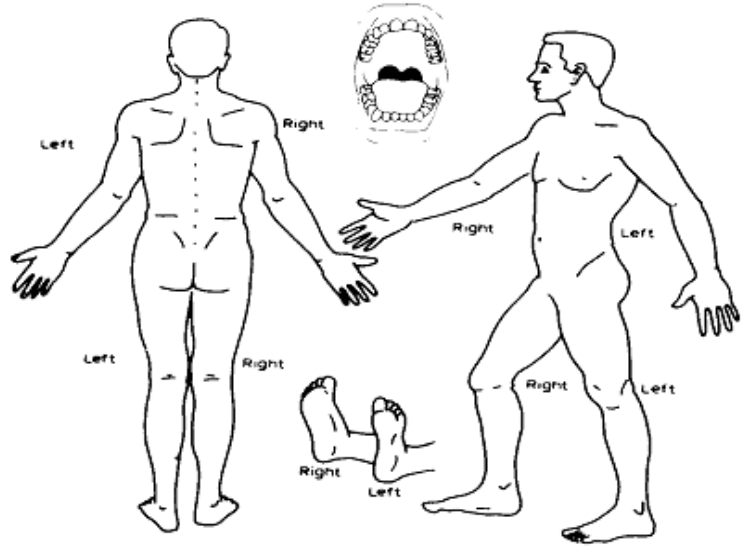
Do you have any other complaints or concerns? _____

What do **you** think is causing your present health problem(s)?

On the diagram to the right, please mark the following symptoms, if you are experiencing them:
“/” for stabbing pain,
“B” for burning pain,
“D” for dull pain,
“A” for aching pain,
“N” or in areas where you have numbness
“T” in areas where you have tingling,
“St” in areas where you feel stiffness,
“Sw” in areas where you’ve had swelling,
“C” in areas where you have cramps,



Below indicate any **other** symptoms you think may be important.



What are your **5 greatest concerns** about your present state of health?

1. _____

2. _____

3. _____

4. _____

5. _____

Doctor's Notes: _____

Doctor's Initials: _____

Please answer the following questions as completely as possible:

Please list all operations or surgeries you may have had with dates: _____

Please list any hospitalizations you may have had with dates: _____

Please list any major illness you have had with dates: _____

Have you had any recent infections, colds, or flu? No. Yes: _____

Please list any and **all** traumas or injuries you've ever had, with dates, from the simple to the serious: _____

Have you ever been diagnosed with a tumor, cancer, neoplasia, or dysplasia? No. Yes: _____

Have you ever been diagnosed with diabetes? No. Yes: _____

Have you ever been diagnosed with a cardiac (heart) condition, a blood vessel condition (like arteriosclerosis, atherosclerosis, or vasculitis), or hypertension (high blood pressure)? No. Yes: _____

Have you ever had a stroke or heart attack? No. Yes: _____

Does anyone in your biological family (parent, grandparent, sibling, or child) have a history of heart disease, stroke, cancer, or diabetes? No. Yes, explain: _____

Does anyone in your biological family have a history of psychiatric diseases like depression, anxiety, schizophrenia, etc? No. Yes, explain: _____

Does anyone in your biological family have a history of neuropathies (nerve diseases) or myopathies (muscle diseases)? No. Yes, explain: _____

Does anyone in your biological family have a history of cancer? No. Yes, explain: _____

Does anyone in your biological family have a history of back or neck pain? No. Yes, explain: _____

Does anyone in your biological family have a history of any other known conditions? No. Yes, explain: _____

Please indicate your familial status? Single. Married. Divorced. Widowed.

How many children do you have? None. 1. 2. 3. 4. Other: _____.

What do you do for a living? _____ . How many hours a week? _____

Do you have a second job? _____ . How many hours a week? _____

Describe your work environment: _____

How long have you been at this job? _____ What other jobs have you had in the past? _____

Describe your home life: _____

What is your highest level of education? _____ . What are your hobbies? _____

Doctor's Notes: _____

Doctor's Initials: _____

Do you exercise? No. Yes, then what type and how often: _____

Do you use any tobacco products? No. Yes, then what kind, how often, & how long: _____

Have you used tobacco products in the past? No. Yes, then what, how long, & when did you quit? _____

Do you drink alcoholic beverages? No. Yes, then what kind and how many a week: _____

Have you had alcohol problems in the past? No. Yes, then how long ago & for how long: _____

Do you drink caffeinated beverages? No. Yes, then what kind and how many a day: _____

Do you drink sodas? No. Yes, then how many a day: _____

Do you use recreational drugs? No. Yes, then how long ago & for how long: _____

Have you used recreational drugs in the past? No. Yes, then what type, when, & for how long: _____

Do you have any special dietary restrictions? No. Yes, then what type: _____

Are you sexually active? No. Yes. If yes have you ever been diagnosed with an STD or VD: _____

When did you last see a chiropractor? _____. What were those visits for & how were the outcomes? _____

Why have you changed chiropractors? _____

Review of Systems & Medical History:

- Are you currently experiencing any of the following symptoms, now or recently?

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Jaw pain	<input type="checkbox"/> Left arm pain
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Excessive sweating without exertion	<input type="checkbox"/> Pale skin or pallor
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Swelling in your left arm	<input type="checkbox"/> Lightheadedness
- Please check off any of the below symptoms that you are be experiencing, now or recently?

<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Difficulty with speaking
<input type="checkbox"/> Dizziness or vertigo	<input type="checkbox"/> Difficulty with swallowing	<input type="checkbox"/> Disequilibrium or feeling unsteady
<input type="checkbox"/> Double vision	<input type="checkbox"/> Feeling like your are going to fall	<input type="checkbox"/> Abnormal eye movements
<input type="checkbox"/> Numbness	<input type="checkbox"/> Abnormal sweating	<input type="checkbox"/> Severe headache
- Have you noticed any of the following? _____

<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Unexplained weight gain	<input type="checkbox"/> Recent fever	<input type="checkbox"/> Recent fatigue
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Please mark any of the below conditions that apply to you, past or present.

<u>Condition</u>	<u>Past</u> <u>Present</u>	<u>Condition</u>	<u>Past</u> <u>Present</u>	<u>Condition</u>	<u>Past</u> <u>Present</u>	<u>Condition</u>	<u>Past</u> <u>Present</u>
<input type="checkbox"/> Swollen or painful joints		<input type="checkbox"/> Foot or ankle pain		<input type="checkbox"/> Trouble with prolonged sitting or standing		<input type="checkbox"/> Herniated disc	
<input type="checkbox"/> Neck pain or stiffness		<input type="checkbox"/> Leg pain		<input type="checkbox"/> Trouble with walking		<input type="checkbox"/> Lumbago or lumbalgia	
<input type="checkbox"/> Upper back pain or stiffness		<input type="checkbox"/> Knee pain		<input type="checkbox"/> Trouble with bending, twisting, or lifting		<input type="checkbox"/> Scoliosis or other spinal curvature	
<input type="checkbox"/> Mid back pain or stiffness		<input type="checkbox"/> Shoulder pain		<input type="checkbox"/> Osteoporosis		<input type="checkbox"/> Difficulty walking	
<input type="checkbox"/> Low back pain or stiffness		<input type="checkbox"/> Elbow pain		<input type="checkbox"/> Dislocated bones		<input type="checkbox"/> Osteoarthritis or DJD	
<input type="checkbox"/> Hip or pelvis pain		<input type="checkbox"/> Arm pain		<input type="checkbox"/> Fractured bones		<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Auto accidents		<input type="checkbox"/> Hand or wrist pain		<input type="checkbox"/> Bone infection (osteomyelitis)		<input type="checkbox"/> Other arthritis	
		<input type="checkbox"/> Jaw pain or click (TMJ)		<input type="checkbox"/> Machine accident		<input type="checkbox"/> Gout	
		<input type="checkbox"/> Chronic headaches				<input type="checkbox"/> Ankylosing spondylitis	
		<input type="checkbox"/> Sprain or strain				<input type="checkbox"/> Accidental fall	
		<input type="checkbox"/> Sports injuries					

Doctor's Notes: _____

Doctor's Initials: _____

<u>Condition</u>	<u>Past</u> <u>Present</u>	<u>Condition</u>	<u>Past</u> <u>Present</u>	<u>Condition</u>	<u>Past</u> <u>Present</u>	<u>Condition</u>	<u>Past</u> <u>Present</u>
<input type="checkbox"/> Migraines		<input type="checkbox"/> Trigeminal neuralgia or Tic Doloreaux		<input type="checkbox"/> Tension headaches		<input type="checkbox"/> Sinus headaches	
<input type="checkbox"/> Cluster headaches		<input type="checkbox"/> Hypertension headache		<input type="checkbox"/> Pain in your face		<input type="checkbox"/> Cervicogenic headaches	
<input type="checkbox"/> Costen's syndrome		<input type="checkbox"/> Seizures		<input type="checkbox"/> Temporal arteritis		<input type="checkbox"/> Other type of headache	
<input type="checkbox"/> Balance problems		<input type="checkbox"/> Neurological disease		<input type="checkbox"/> Trouble sleeping		<input type="checkbox"/> Recent incoordination	
<input type="checkbox"/> Mental or emotional disorder		<input type="checkbox"/> Trouble concentrating		<input type="checkbox"/> Difficulty with focus		<input type="checkbox"/> Head seems heavy/tired	
<input type="checkbox"/> Convulsions or epilepsy		<input type="checkbox"/> Difficulty swallowing		<input type="checkbox"/> Loss of memory		<input type="checkbox"/> Head or arms feel tired	
<input type="checkbox"/> Difficulty speaking		<input type="checkbox"/> Trouble understanding others		<input type="checkbox"/> Fainting spells		<input type="checkbox"/> Loss of consciousness	
<input type="checkbox"/> Difficulty swallowing		<input type="checkbox"/> Stroke or CVA		<input type="checkbox"/> Tire easily		<input type="checkbox"/> Concussions	
<input type="checkbox"/> Losing time or blacking out		<input type="checkbox"/> Paralysis		<input type="checkbox"/> Mini-stroke or TIA		<input type="checkbox"/> Head injury	
<input type="checkbox"/> Changes in skin sensation		<input type="checkbox"/> Muscle weakness		<input type="checkbox"/> Blurred vision		<input type="checkbox"/> Persistent headache	
<input type="checkbox"/> Muscle problems		<input type="checkbox"/> Twitching muscles		<input type="checkbox"/> Double vision		<input type="checkbox"/> Spontaneous movement	
<input type="checkbox"/> Learning disability		<input type="checkbox"/> Lost muscle tone		<input type="checkbox"/> Muscle cramping		<input type="checkbox"/> Weak muscles of face	
<input type="checkbox"/> Conduct disorder		<input type="checkbox"/> ADD or ADHD		<input type="checkbox"/> Tremors (shaking)		<input type="checkbox"/> Numbness or tingling	
<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Behavioral disorder		<input type="checkbox"/> Abnormal movements		<input type="checkbox"/> Excessive sweating	
<input type="checkbox"/> Dizziness		<input type="checkbox"/> Macular degeneration		<input type="checkbox"/> Dyslexia		<input type="checkbox"/> Autism (PDD or ASD)	
<input type="checkbox"/> Motion sickness		<input type="checkbox"/> Vertigo		<input type="checkbox"/> Asperger's syndrome		<input type="checkbox"/> Bedwetting	
<input type="checkbox"/> Ear infections		<input type="checkbox"/> Unexplained giddiness		<input type="checkbox"/> Cataracts		<input type="checkbox"/> Retinopathy	
<input type="checkbox"/> Tinnitus		<input type="checkbox"/> Ringing in ears		<input type="checkbox"/> Unsteadiness		<input type="checkbox"/> Pain with coughing or sneezing	
<input type="checkbox"/> Sore throat		<input type="checkbox"/> Sinus problems		<input type="checkbox"/> Difficult with balance		<input type="checkbox"/> Hearing loss	
<input type="checkbox"/> Pain in legs with movement or activity		<input type="checkbox"/> Mouth sores		<input type="checkbox"/> Earaches		<input type="checkbox"/> Difficulty swallowing	
<input type="checkbox"/> Heart palpations (hearing racing heart)		<input type="checkbox"/> Heart attack (myocardial infarct)		<input type="checkbox"/> Nose bleeds		<input type="checkbox"/> Hoarseness	
<input type="checkbox"/> Swelling in legs or feet		<input type="checkbox"/> Irregular heart beats		<input type="checkbox"/> Bleeding gums		<input type="checkbox"/> High cholesterol	
<input type="checkbox"/> Congestive heart failure		<input type="checkbox"/> Experience passing out		<input type="checkbox"/> Arrhythmia		<input type="checkbox"/> High blood pressure (hypertension)	
<input type="checkbox"/> Difficulty breathing		<input type="checkbox"/> Skipped heart beats		<input type="checkbox"/> Heart murmur		<input type="checkbox"/> Scarlet fever	
<input type="checkbox"/> Chronic/frequent cough		<input type="checkbox"/> Congenital heart disease		<input type="checkbox"/> Atherosclerosis / arteriosclerosis		<input type="checkbox"/> Rheumatic fever	
<input type="checkbox"/> COPD		<input type="checkbox"/> Shortness of breath with activity		<input type="checkbox"/> Dizzy or light-headed with exercise		<input type="checkbox"/> Other heart disease	
<input type="checkbox"/> Coughing up blood		<input type="checkbox"/> Short of breath at rest		<input type="checkbox"/> Wheezing		<input type="checkbox"/> Emphysema	
<input type="checkbox"/> Difficulty losing weight		<input type="checkbox"/> Painful breathing		<input type="checkbox"/> Asthma		<input type="checkbox"/> Bronchitis	
<input type="checkbox"/> Colon problems		<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Coughing up mucus		<input type="checkbox"/> Snoring	
<input type="checkbox"/> Gall bladder trouble		<input type="checkbox"/> Difficulty with control of bowel movements		<input type="checkbox"/> Pneumothorax		<input type="checkbox"/> Other lung problems	
<input type="checkbox"/> Liver disease		<input type="checkbox"/> Nausea &/or vomiting		<input type="checkbox"/> Difficulty swallowing		<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Stomach/duodenal ulcer		<input type="checkbox"/> Digestive problems		<input type="checkbox"/> Gall bladder stones		<input type="checkbox"/> More than 3 bowel movements a day	
<input type="checkbox"/> Abdominal pain		<input type="checkbox"/> Constipation		<input type="checkbox"/> Intestinal issues		<input type="checkbox"/> Less than 1 bowel movement a day	
<input type="checkbox"/> Indigestion		<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Heartburn		<input type="checkbox"/> Excessive gas	
<input type="checkbox"/> Cirrhosis		<input type="checkbox"/> Polyps		<input type="checkbox"/> Gastric ulcers		<input type="checkbox"/> Blood in stool	
<input type="checkbox"/> Bloating		<input type="checkbox"/> Diverticulitis		<input type="checkbox"/> Excessive belching		<input type="checkbox"/> Ulcerative colitis	
<input type="checkbox"/> Craving sweets		<input type="checkbox"/> Hormonal issues		<input type="checkbox"/> Digestive issues		<input type="checkbox"/> Crohn's disease	
<input type="checkbox"/> Craving excessive salts		<input type="checkbox"/> Thyroid disorder		<input type="checkbox"/> Celiac Disease (Sprue)		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Pituitary disorder		<input type="checkbox"/> Adrenal disorder		<input type="checkbox"/> Irritable bowel syndrm.		<input type="checkbox"/> Hyperthyroidism	
<input type="checkbox"/> Cold all the time		<input type="checkbox"/> Hot all the time		<input type="checkbox"/> Night sweats		<input type="checkbox"/> Hypothyroidism	
<input type="checkbox"/> Dry skin		<input type="checkbox"/> Trouble with sleep		<input type="checkbox"/> Decreased energy		<input type="checkbox"/> Excessive thirst	
<input type="checkbox"/> Change in hat size		<input type="checkbox"/> Change in glove size		<input type="checkbox"/> Frequent urination		<input type="checkbox"/> Decreased sex drive	
<input type="checkbox"/> Unexplained skin rash		<input type="checkbox"/> Itching		<input type="checkbox"/> Hair loss		<input type="checkbox"/> Change in skin color	
<input type="checkbox"/> Change in skin mole		<input type="checkbox"/> Eczema		<input type="checkbox"/> Increased sex drive		<input type="checkbox"/> Shingles	
<input type="checkbox"/> Seborrhea		<input type="checkbox"/> Dermatitis		<input type="checkbox"/> Under a lot of stress		<input type="checkbox"/> Herpes	
<input type="checkbox"/> Acne				<input type="checkbox"/> Change in hair pattern		<input type="checkbox"/> Warts	
				<input type="checkbox"/> Bruise easy		<input type="checkbox"/> Other skin disorder	
				<input type="checkbox"/> Psoriasis			
				<input type="checkbox"/> Skin cancer			

HxA-fn

HxA-GI

HxA-En

Doctor's Notes: _____

Doctor's Initials: _____

<p>Condition</p> <input type="checkbox"/> Psychological issues <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Irritability <input type="checkbox"/> Prostate problems <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Problems with sexual libido or desire <input type="checkbox"/> Discharge from urethra <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Anemia <input type="checkbox"/> Allergies <input type="checkbox"/> The flu, how long ago <hr/>	<div style="border: 1px solid black; padding: 2px; display: inline-block; transform: rotate(-45deg);">Past</div> <div style="border: 1px solid black; padding: 2px; display: inline-block; transform: rotate(45deg);">Present</div>	<p>Condition</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Feelings of hopelessness <input type="checkbox"/> Phobias <input type="checkbox"/> HPV / genital warts <input type="checkbox"/> PMS problems <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Breast discharge <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Breast lumps / soreness <input type="checkbox"/> Menopause <input type="checkbox"/> Vascular disease <input type="checkbox"/> Varicose veins <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> A cold, how long ago <hr/>	<div style="border: 1px solid black; padding: 2px; display: inline-block; transform: rotate(-45deg);">Past</div> <div style="border: 1px solid black; padding: 2px; display: inline-block; transform: rotate(45deg);">Present</div>	<p>Condition</p> <input type="checkbox"/> Panic attacks <input type="checkbox"/> Mood changes <input type="checkbox"/> PTSD <input type="checkbox"/> OCD <input type="checkbox"/> Syphilis <input type="checkbox"/> Kidney problems or disease <input type="checkbox"/> Kidney stones <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Feelings of urgency to urinate <input type="checkbox"/> Leg pain with walking <input type="checkbox"/> Blood clots / phlebitis <input type="checkbox"/> Frequent colds or flues <input type="checkbox"/> Alcoholism <input type="checkbox"/> Cancer <hr/>	<div style="border: 1px solid black; padding: 2px; display: inline-block; transform: rotate(-45deg);">Past</div> <div style="border: 1px solid black; padding: 2px; display: inline-block; transform: rotate(45deg);">Present</div>	<p>Condition</p> <input type="checkbox"/> Work or social stress <input type="checkbox"/> Anger easy <input type="checkbox"/> Feelings of suicide <input type="checkbox"/> Eating disorders <input type="checkbox"/> Infrequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Awaken to urinate <input type="checkbox"/> Bladder infections <input type="checkbox"/> Other STD / VD <input type="checkbox"/> Venous insufficiency <input type="checkbox"/> Bruise easily <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Other: <hr/>	<div style="border: 1px solid black; padding: 2px; display: inline-block; transform: rotate(-45deg);">Past</div> <div style="border: 1px solid black; padding: 2px; display: inline-block; transform: rotate(45deg);">Present</div>	<div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p style="text-align: center;">Hx-M/A</p> <hr/> <p style="text-align: center;">HxA-M HxA-F</p> <hr/> <hr/> <hr/> </div>
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Females only:
 Is there **any** possibility that you are currently pregnant? No. Yes.
 What was the date of your last menstrual period? _____.

You may describe any other concerns or questions in this space below:

Thank you for taking the time to fill out this health history questionnaire. This information is important in the doctor obtaining a clinical picture so as to make an appropriate diagnosis & treatment plan. Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by your doctor at ADIO Wellness Center. Any disclosure is outlined in our privacy policies.

_____ Patient's signature (or guardian's signature)
 _____ Date

_____ Signature of translator or person assisting with this form (if any)
 Printed name of said person _____ Date

Doctor's Notes: _____

Doctor's Initials: _____