

Wellspring Chiropractic and Acupuncture Center  
2348 NC Hwy 105, Heritage Court Suite #9  
Boone, North Carolina 28607

828-265-0001  
Fax- 828-265-0117

Dear New Wellspring Patient,

Welcome to Wellspring!! We look forward to helping you to achieve your health goals. Whether your desire is simply pain relief or comprehensive wellness care, we are committed to helping you to achieve that desire.

The following pages contain a very detailed health history form. Please complete this form as completely as possible. It is important that I have so comprehensive a picture of your entire state of health so that the correct diagnosis and individualized treatment plan be designed for you. You might think certain questions are unrelated to your current condition and withhold that information. On the contrary, this information might be just what we need to figure out the best and quickest way to heal you.

You may notice some differences in our approach to healing. We treat the whole person, not just a set of symptoms. We expect you to take an active role in reclaiming your health. We will gladly work with your other health care providers, or refer you to them to facilitate your further healing. Once your condition is resolved, we expect you to maintain your health by practicing the health habits we have taught you, and come in periodically for "tune ups."

We are deeply honored by your choice of Wellspring to help with your health care. We would like to make your experience here a positive one. Please let us know how we can better serve you.

Be well,

Dr. Bonnie & Staff of Wellspring

# Confidential Patient Contact Information

First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Preferred Name \_\_\_\_\_

Local Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Sex: M  F  Marital status: Single  Married  Widowed

Phone #s (Which one is best to contact you during the day?) Home  Work  Cell

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-mail (Only Used for Reminders) \_\_\_\_\_ @ \_\_\_\_\_

Social Security #(Only Needed for Insurance Purposes) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

May we contact them about your case? No  Yes

*If Yes, Please sign the **Authorization to Release Medical Information Form***

Patient's Occupation \_\_\_\_\_

Patient's Employer \_\_\_\_\_

Employer's Address City \_\_\_\_\_ State \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address City \_\_\_\_\_ State \_\_\_\_\_

## Responsible party (if not patient)

Relationship \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Name of Responsible Party \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

## INSURANCE INFORMATION

Do you have medical insurance? No  Yes  *If Yes, Please bring insurance card with you*

Name of *Primary* Insurance Co \_\_\_\_\_

Policy \_\_\_\_\_ Group \_\_\_\_\_

Name of *Secondary* Insurance Co \_\_\_\_\_

Policy \_\_\_\_\_ Group \_\_\_\_\_

## How did you hear of our practice?

Flyer \_\_\_ Yellow Pages \_\_\_ Website \_\_\_ Other \_\_\_\_\_

Friend/Relative \_\_\_ Name? (optional) \_\_\_\_\_

# Patient Medical History Form

Name \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Describe your general state of health. \_\_\_\_\_

When was it you last felt well? \_\_\_\_\_

What type of care do you desire?

- \_\_\_\_\_ 1) Temporary relief of symptoms / pain control
- \_\_\_\_\_ 2) Removing the tendencies causing my condition
- \_\_\_\_\_ 3) Balanced optimum health care. Elimination of root/cause of problem, if possible
- \_\_\_\_\_ 4) Maintenance / wellness care

How would you classify your condition?

- \_\_\_\_\_ 1) Minor
- \_\_\_\_\_ 2) Moderate
- \_\_\_\_\_ 3) Intensifying, affecting daily activities
- \_\_\_\_\_ 4) Fairly severe, progressively getting worse or more worrisome
- \_\_\_\_\_ 5) Serious

Please state and describe the problem(s) or condition(s) concerning you

**# 1 Problem** \_\_\_\_\_

When did it occur? \_\_\_\_\_ How? \_\_\_\_\_

Timing: Is it getting: better \_\_\_\_ worse \_\_\_\_ constant \_\_\_\_ worsens at (time of day) \_\_\_\_\_

What makes it worse? \_\_\_\_\_ What makes it better? \_\_\_\_\_

Are there any other symptoms which occur along with this problem? No \_\_\_\_ Yes \_\_\_\_

Describe other symptoms \_\_\_\_\_

**# 2 Problem** \_\_\_\_\_

When did it occur? \_\_\_\_\_ How? \_\_\_\_\_

Timing: Is it getting: better \_\_\_\_ worse \_\_\_\_ constant \_\_\_\_ worsens at (time of day) \_\_\_\_\_

What makes it worse? \_\_\_\_\_ What makes it better? \_\_\_\_\_

Are there any other symptoms which occur along with this problem? No \_\_\_\_ Yes \_\_\_\_

Describe other symptoms \_\_\_\_\_

**# 3 Problem** \_\_\_\_\_

When did it occur? \_\_\_\_\_ How? \_\_\_\_\_

Timing: Is it getting: better \_\_\_\_ worse \_\_\_\_ constant \_\_\_\_ worsens at (time of day) \_\_\_\_\_

What makes it worse? \_\_\_\_\_ What makes it better? \_\_\_\_\_

Are there any other symptoms which occur along with this problem? No \_\_\_\_ Yes \_\_\_\_

Describe other symptoms \_\_\_\_\_

# Past Medical History

*Please **answer all questions as completely as possible**, even though it may not seem relevant to your current condition. In many cases, **it is very relevant**.*

Date of last physical exam: \_\_\_\_\_ Doctor \_\_\_\_\_

Results of exam \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Any recent changes? \_\_\_\_\_ # Gain? \_\_\_\_\_ # Loss? \_\_\_\_\_

Allergies? No  Yes  Allergic To \_\_\_\_\_

**Please list any other treatments you have tried, results, and practitioner (if applicable).**

Condition Treated For	Treatment by	Practitioner's Name (If Applicable)	Results
_____	Chiropractic	_____	_____
_____	Acupuncture	_____	_____
_____	Medical Doctor	_____	_____
_____	Physical Therapy	_____	_____
_____	Massage	_____	_____
_____	Aspirin, Ibuprofen, Tylenol, etc	_____	_____
_____	Ice, Heat	_____	_____
_____	Other	_____	_____

### Medications currently taking or recently prescribed:

Name \_\_\_\_\_ For \_\_\_\_\_

Name \_\_\_\_\_ For \_\_\_\_\_

Name \_\_\_\_\_ For \_\_\_\_\_

Name \_\_\_\_\_ For \_\_\_\_\_

Name \_\_\_\_\_ For \_\_\_\_\_

Name \_\_\_\_\_ For \_\_\_\_\_

# SERIOUS ILLNESSES TRAUMAS, ACCIDENTS, SURGERIES, ETC.

List any which made you very ill, had high fever, recurred, required hospitalization or took long to resolve, and your age. *Include childhood and adult illnesses.*

*Please answer all questions as completely as possible, even though it may not seem relevant to your current condition. In many cases, it is very relevant.*

Problem #1 \_\_\_\_\_ When (or age) \_\_\_\_\_

Describe problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Problem #2 \_\_\_\_\_ When (or age) \_\_\_\_\_

Describe problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Problem #3 \_\_\_\_\_ When (or age) \_\_\_\_\_

Describe problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Problem #4 \_\_\_\_\_ When (or age) \_\_\_\_\_

Describe problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Problem #5 \_\_\_\_\_ When (or age) \_\_\_\_\_

Describe problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Problem #6 \_\_\_\_\_ When (or age) \_\_\_\_\_

Describe problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's Name \_\_\_\_\_

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# Family Health History

Have you or any blood relative ever been diagnosed or treated for the following conditions?

*Please answer all questions as completely as possible, even though it may not seem relevant to your current condition. In many cases, it is very relevant.*

Patient's Condition	When	Relative's Condition
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Diabetes
<input type="checkbox"/> TB /tuberculosis	_____	<input type="checkbox"/> TB /tuberculosis
<input type="checkbox"/> Hepatitis A, B, C	_____	<input type="checkbox"/> Hepatitis A, B, C
<input type="checkbox"/> Heart disease	_____	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Stroke
<input type="checkbox"/> Kidney disease	_____	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Cancer
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Anemia
<input type="checkbox"/> Headaches	_____	<input type="checkbox"/> Headaches
<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Mental illness	_____	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Back Pain	_____	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Addiction	_____	<input type="checkbox"/> Addiction
To What? _____		To What? _____

**Do you or have you had?:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> fainting easily | <input type="checkbox"/> breathing problems | <input type="checkbox"/> HIV/AIDS                  |
| <input type="checkbox"/> bruise easily   | <input type="checkbox"/> presently hungry   | <input type="checkbox"/> high blood pressure       |
| <input type="checkbox"/> slow clotting   | <input type="checkbox"/> hepatitis          | <input type="checkbox"/> presently exhausted       |
| <input type="checkbox"/> heart problems  | Which Type? A __ B __ C __                  | <input type="checkbox"/> presently anxious/nervous |

Level of stress you are currently experiencing: Low  Moderate  High  Extreme

## Indicate Average Use or Consumption

*(Please be honest... This information is confidential & **very important**)*

*Please **answer all questions as completely as possible**, even though it may not seem relevant to your current condition. In many cases, **it is very relevant.***

Use of	Type	Quantity	Frequency
Alcohol	_____	_____	_____
Tobacco	_____	_____	_____
Sweets	_____	_____	_____
Coffee	_____	_____	_____
Recreational drugs	_____	_____	_____
Water	_____	_____	_____
Exercise	_____	_____	_____
Tea	_____	_____	_____
Meditation	_____	_____	_____
Sodas	_____	_____	_____

**Blood type:**       A    B    O    A B       Not sure

**Please describe your average daily diet:**

**Breakfast** \_\_\_\_\_

\_\_\_\_\_

**Lunch** \_\_\_\_\_

\_\_\_\_\_

**Dinner** \_\_\_\_\_

\_\_\_\_\_

**Snacks** \_\_\_\_\_

\_\_\_\_\_

Do you have specific food cravings?    No \_\_\_ Yes \_\_\_

If Yes .... What are they? Sour \_\_\_ Bitter \_\_\_ Sweet \_\_\_ Spicy \_\_\_ Salty \_\_\_

Other \_\_\_\_\_

When do they most often occur? \_\_\_\_\_

## Indicate whether your symptoms are:

**1 = Mild/Occasional 2=Moderate/recurrent 3=Severe/Constant/Chronic**

*Please **answer all questions as completely as possible**, even though it may not seem relevant to your current condition. In many cases, **it is very relevant.***

### GENERAL

- \_\_\_\_\_ Tremors
- \_\_\_\_\_ Fever
- \_\_\_\_\_ Sweats
- \_\_\_\_\_ Fainting
- \_\_\_\_\_ Convulsions
- \_\_\_\_\_ Lack of sleep
- \_\_\_\_\_ Fatigue
- \_\_\_\_\_ Nervousness
- \_\_\_\_\_ Depression
- \_\_\_\_\_ Confusion
- \_\_\_\_\_ Compulsiveness
- \_\_\_\_\_ Unexplained weight loss/gain
- \_\_\_\_\_ Paralysis
- \_\_\_\_\_ Numbness
- \_\_\_\_\_ Pain (Where?) \_\_\_\_\_
- \_\_\_\_\_ Addiction
- \_\_\_\_\_ Auto immune disease
- \_\_\_\_\_ Seasonal affective disorder
- \_\_\_\_\_ Mood swings
- \_\_\_\_\_ Overweight
- \_\_\_\_\_ Underweight
- \_\_\_\_\_ Other \_\_\_\_\_

### EYES

- \_\_\_\_\_ Blurred vision
- \_\_\_\_\_ Eyelid problem
- \_\_\_\_\_ Eye pain
- \_\_\_\_\_ Eye strain
- \_\_\_\_\_ Nearsightedness
- \_\_\_\_\_ Double vision
- \_\_\_\_\_ Lazy eye
- \_\_\_\_\_ Red, itchy, watery eyes
- \_\_\_\_\_ Glaucoma
- \_\_\_\_\_ Macular degeneration
- \_\_\_\_\_ Cataracts
- \_\_\_\_\_ Other \_\_\_\_\_

### EARS

- \_\_\_\_\_ Hearing loss
- \_\_\_\_\_ Ear pain
- \_\_\_\_\_ Ear infections
- \_\_\_\_\_ Ear discharge
- \_\_\_\_\_ Itching
- \_\_\_\_\_ Ringing, noises
- \_\_\_\_\_ Other \_\_\_\_\_

### HEAD & FACE

- \_\_\_\_\_ Discolorations
- \_\_\_\_\_ Headaches
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Memory loss
- \_\_\_\_\_ Pain
- \_\_\_\_\_ Paralysis
- \_\_\_\_\_ Swelling
- \_\_\_\_\_ Numbness
- \_\_\_\_\_ Other \_\_\_\_\_

### NOSE AND SINUSES

- \_\_\_\_\_ Frequent colds
- \_\_\_\_\_ Nasal congestion
- \_\_\_\_\_ Nasal discharge
- \_\_\_\_\_ Color of discharge \_\_\_\_\_
- \_\_\_\_\_ Itching
- \_\_\_\_\_ Sores/lesions
- \_\_\_\_\_ Nosebleeds
- \_\_\_\_\_ Sinus congestion
- \_\_\_\_\_ Diminished sense of smell
- \_\_\_\_\_ Allergies
- \_\_\_\_\_ To what? \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

**Indicate whether your symptoms are:**

**1 = Mild/Occasional 2=Moderate/recurrent 3=Severe/Constant/Chronic**

*Please answer all questions as completely as possible, even though it may not seem relevant to your current condition. In many cases, it is very relevant.*

**MOUTH & THROAT**

- \_\_\_\_\_ Tooth problems
- \_\_\_\_\_ Loss of sense of taste
- \_\_\_\_\_ Unusual taste
- \_\_\_\_\_ Gum problems
- \_\_\_\_\_ Tongue problems
- \_\_\_\_\_ Feeling of lump in throat
- \_\_\_\_\_ Lip problems
- \_\_\_\_\_ Jaw problems
- \_\_\_\_\_ Speech problems
- \_\_\_\_\_ Sores in mouth
- \_\_\_\_\_ # Teeth missing \_\_\_\_\_
- \_\_\_\_\_ Dentures / implants
- \_\_\_\_\_ Sore throat
- \_\_\_\_\_ Hoarseness
- \_\_\_\_\_ Lumps in neck
- \_\_\_\_\_ Swollen glands
- \_\_\_\_\_ Goiter (swollen thyroid)
- \_\_\_\_\_ Neck pain
- \_\_\_\_\_ Difficulty swallowing
- \_\_\_\_\_ Stiff neck
- \_\_\_\_\_ Burning in mouth
- \_\_\_\_\_ Other \_\_\_\_\_

**GASTROINTESTINAL/DIGESTION**

- \_\_\_\_\_ Flatulence (gas in bowels)
- \_\_\_\_\_ Hemorrhoids
- \_\_\_\_\_ Diarrhea
- \_\_\_\_\_ Loose stools
- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Hiatal hernia
- \_\_\_\_\_ Parasites When ? \_\_\_\_\_
- \_\_\_\_\_ Stomach / duodenal ulcer
- \_\_\_\_\_ Black tarry stools
- \_\_\_\_\_ Pale stools
- \_\_\_\_\_ Liver problems
- \_\_\_\_\_ Hepatitis (circle which type) a b c
- \_\_\_\_\_ Rectal bleeding
- \_\_\_\_\_ Jaundice
- \_\_\_\_\_ Gallbladder problems
- \_\_\_\_\_ Difficulty losing / gaining weight
- \_\_\_\_\_ Recent rapid weight loss/gain # \_\_\_\_\_ lbs
- \_\_\_\_\_ Eating disorder
- \_\_\_\_\_ Food intolerances / allergies
- \_\_\_\_\_ Other \_\_\_\_\_

**GASTROINTESTINAL/DIGESTION**

- \_\_\_\_\_ Thirst excessive / average / none (circle appropriate)
- \_\_\_\_\_ Skin itching
- \_\_\_\_\_ Hunger excessive / average / none (circle appropriate)
- \_\_\_\_\_ Difficulty chewing food
- \_\_\_\_\_ Difficulty swallowing food/ water (circle appropriate)
- \_\_\_\_\_ Heartburn / reflux
- \_\_\_\_\_ Nausea
- \_\_\_\_\_ Vomiting
- \_\_\_\_\_ Belching / bloating / gas
- \_\_\_\_\_ Stomach / abdominal pain

**GENITOURINARY**

- \_\_\_\_\_ Difficulty urinating
- \_\_\_\_\_ Burning or pain on urination
- \_\_\_\_\_ Dribbling / leaking / incontinence
- \_\_\_\_\_ Frequent urination
- \_\_\_\_\_ Blood / pus in urine
- \_\_\_\_\_ Discolored urine
- \_\_\_\_\_ Nighttime urination # \_\_\_\_\_/night
- \_\_\_\_\_ Bladder infections / cystitis
- \_\_\_\_\_ Kidney stones
- \_\_\_\_\_ Kidney infections
- \_\_\_\_\_ Bedwetting
- \_\_\_\_\_ Other \_\_\_\_\_

## Indicate whether your symptoms are:

**1 = Mild/Occasional 2=Moderate/recurrent 3=Severe/Constant/Chronic**

*Please answer all questions as completely as possible, even though it may not seem relevant to your current condition. In many cases, it is very relevant.*

### LUNGS

- \_\_\_\_\_ Cough
- \_\_\_\_\_ Sputum / phlegm
- \_\_\_\_\_ Color
- \_\_\_\_\_ Wheezing / asthma
- \_\_\_\_\_ Difficulty inhaling / exhaling (Which?)
- \_\_\_\_\_ Allergies
- \_\_\_\_\_ Bronchitis
- \_\_\_\_\_ Pneumonia
- \_\_\_\_\_ Emphysema / COPD
- \_\_\_\_\_ Tuberculosis
- \_\_\_\_\_ Pleurisy
- \_\_\_\_\_ Shortness of breath
- \_\_\_\_\_ Smoker \_\_\_\_\_ pks / day for \_\_\_\_\_ yrs
- \_\_\_\_\_ Ex-smoker/\_\_\_\_\_quit (date)
- \_\_\_\_\_ Date of last chest x-ray
- \_\_\_\_\_ Other \_\_\_\_\_

### CARDIOVASCULAR

- \_\_\_\_\_ High blood pressure
- \_\_\_\_\_ Low blood pressure
- \_\_\_\_\_ Palpitations
- \_\_\_\_\_ Tightness / pain in chest
- \_\_\_\_\_ Difficulty lying flat
- \_\_\_\_\_ Rapid heartbeat
- \_\_\_\_\_ Slow heartbeat
- \_\_\_\_\_ Irregular heartbeat
- \_\_\_\_\_ Pain over heart
- \_\_\_\_\_ Prior heart attack \_\_\_\_\_ date
- \_\_\_\_\_ Hardening of the arteries
- \_\_\_\_\_ Prior stroke \_\_\_\_\_ date
- \_\_\_\_\_ Ankles swell
- \_\_\_\_\_ Poor circulation
- \_\_\_\_\_ Cold feet
- \_\_\_\_\_ Hot feet

### CARDIOVASCULAR (continued)

- \_\_\_\_\_ Poor circulation
- \_\_\_\_\_ Restless legs
- \_\_\_\_\_ Varicose veins
- \_\_\_\_\_ Thrombophlebitis
- \_\_\_\_\_ Vein surgery
- \_\_\_\_\_ Leg pains
- \_\_\_\_\_ Cold hands
- \_\_\_\_\_ Hot hands
- \_\_\_\_\_ Cold limbs
- \_\_\_\_\_ Other \_\_\_\_\_

### MUSCULOSKELETAL

- \_\_\_\_\_ Neck pain
- \_\_\_\_\_ Upper back pain
- \_\_\_\_\_ Mid back pain
- \_\_\_\_\_ Lower back pain
- \_\_\_\_\_ Painful tailbone
- \_\_\_\_\_ Spinal curvature / scoliosis
- \_\_\_\_\_ Bad posture
- \_\_\_\_\_ Hernia
- \_\_\_\_\_ Joint pain (Where?) \_\_\_\_\_
- \_\_\_\_\_ Swollen joints
- \_\_\_\_\_ Hot, inflamed joints
- \_\_\_\_\_ Stiff joints (Where?) \_\_\_\_\_
- \_\_\_\_\_ Arthritis
- \_\_\_\_\_ Sciatica
- \_\_\_\_\_ Foot trouble
- \_\_\_\_\_ Difficulty walking
- \_\_\_\_\_ Sore / tired / weak muscles
- \_\_\_\_\_ Rheumatic / scarlet fever
- \_\_\_\_\_ Heart murmur
- \_\_\_\_\_ Smothering sensations
- \_\_\_\_\_ Other \_\_\_\_\_
- \_\_\_\_\_ Date of last EKG \_\_\_\_\_

## Indicate whether your symptoms are:

**1 = Mild/Occasional 2=Moderate/recurrent 3=Severe/Constant/Chronic**

*Please answer all questions as completely as possible, even though it may not seem relevant to your current condition. In many cases, it is very relevant.*

### Sleep

- \_\_\_\_\_ Difficulty falling asleep
- \_\_\_\_\_ Difficulty staying asleep
- \_\_\_\_\_ Awakened by pain/need to urinate/noise (Circle which)
- \_\_\_\_\_ Reduced sexual desire
- \_\_\_\_\_ Normally wakes @ \_\_\_\_\_
- \_\_\_\_\_ Unrefreshing sleep
- \_\_\_\_\_ Vivid / disturbing dreams
- \_\_\_\_\_ Can't recall dreams
- \_\_\_\_\_ Racing thoughts
- \_\_\_\_\_ Need meds to sleep
- \_\_\_\_\_ Other \_\_\_\_\_

### NEUROLOGIC

- \_\_\_\_\_ Fainting
- \_\_\_\_\_ Blackouts
- \_\_\_\_\_ Seizures
- \_\_\_\_\_ Paralysis
- \_\_\_\_\_ Numbness
- \_\_\_\_\_ Tingling
- \_\_\_\_\_ Tremors
- \_\_\_\_\_ Dizziness/vertigo
- \_\_\_\_\_ Tics/involuntary motions

### HEMATOLOGIC

- \_\_\_\_\_ Anemia
- \_\_\_\_\_ Easy bruising
- \_\_\_\_\_ Easy bleeding
- \_\_\_\_\_ Past transfusions
- \_\_\_\_\_ Transfusion reactions
- \_\_\_\_\_ Inherited bleeding diseases
- \_\_\_\_\_ Excessive hunger
- \_\_\_\_\_ Leukemia When? \_\_\_\_\_
- \_\_\_\_\_ Hemorrhage/blood loss \_\_\_\_\_ age
- \_\_\_\_\_ Other \_\_\_\_\_

### SKIN

- \_\_\_\_\_ Easy bruising
- \_\_\_\_\_ Easy bleeding / slow clotting
- \_\_\_\_\_ Excessively dry / oily skin (Circle which)
- \_\_\_\_\_ Moles (color?) \_\_\_\_\_
- \_\_\_\_\_ Wounds slow to heal
- \_\_\_\_\_ Excessive sweating
- \_\_\_\_\_ Rarely sweat
- \_\_\_\_\_ Night sweats
- \_\_\_\_\_ Skin rashes
- \_\_\_\_\_ Other \_\_\_\_\_

### ENDOCRINE

- \_\_\_\_\_ Underactive thyroid
- \_\_\_\_\_ Overactive thyroid
- \_\_\_\_\_ Graves disease When? \_\_\_\_\_
- \_\_\_\_\_ Hashimoto's thyroiditis When? \_\_\_\_\_
- \_\_\_\_\_ Heat intolerance
- \_\_\_\_\_ Cold intolerance
- \_\_\_\_\_ Excessive sweating
- \_\_\_\_\_ Diabetes When? \_\_\_\_\_
- \_\_\_\_\_ Excessive thirst
- \_\_\_\_\_ Excessive urination
- \_\_\_\_\_ Other \_\_\_\_\_

**Indicate whether your symptoms are:**

**1 = Mild/Occasional 2=Moderate/recurrent 3=Severe/Constant/Chronic**

*Please answer all questions as completely as possible, even though it may not seem relevant to your current condition. In many cases, it is very relevant.*

**FEMALE**

- \_\_\_\_\_ Painful menses/ovulation
- \_\_\_\_\_ Bleeding light/moderate/heavy
- \_\_\_\_\_ Clotting/dried brownish blood
- \_\_\_\_\_ Monthly cycle is \_\_\_\_\_days
- \_\_\_\_\_ Bleeding is \_\_\_\_\_days
- \_\_\_\_\_ Spotting \_\_\_\_\_ When?
- \_\_\_\_\_ Menopausal symptoms
- \_\_\_\_\_ Hot flashes
- \_\_\_\_\_ Irregular cycle \_\_\_\_\_
- \_\_\_\_\_ Vaginal discharge
- \_\_\_\_\_ Color? \_\_\_\_\_ Odor? \_\_\_\_\_
- \_\_\_\_\_ Vaginal dryness
- \_\_\_\_\_ Breast swelling
- \_\_\_\_\_ Breast pain
- \_\_\_\_\_ Pelvic/vaginal pain

- \_\_\_\_\_ Sexually transmitted disease
- \_\_\_\_\_ Which? \_\_\_\_\_
- \_\_\_\_\_ Breast lump
- \_\_\_\_\_ Nipple discharge
- \_\_\_\_\_ Endometriosis
- \_\_\_\_\_ Ovarian cysts
- \_\_\_\_\_ Breast cysts
- \_\_\_\_\_ Last pelvic exam
- \_\_\_\_\_ Date \_\_\_\_\_
- \_\_\_\_\_ Self breast exam
- \_\_\_\_\_ How often? \_\_\_\_\_
- \_\_\_\_\_ Are you pregnant?
- \_\_\_\_\_ *Circle one* Yes No Maybe
- \_\_\_\_\_ Birth control
- \_\_\_\_\_ method \_\_\_\_\_
- \_\_\_\_\_ Difficulty / pain achieving orgasm
- \_\_\_\_\_ Age @ start of menses
- \_\_\_\_\_ \_\_\_\_\_
- \_\_\_\_\_ Date of last menstrual period
- \_\_\_\_\_ \_\_\_\_\_

**FEMALE (continued)**

- \_\_\_\_\_ Pregnancies # \_\_\_\_\_
- \_\_\_\_\_ Deliveries # \_\_\_\_\_
- \_\_\_\_\_ Abortions # \_\_\_\_\_
- \_\_\_\_\_ Miscarriages # \_\_\_\_\_
- \_\_\_\_\_ Complications \_\_\_\_\_
- \_\_\_\_\_ Gynecological surgeries \_\_\_\_\_
- \_\_\_\_\_ History of rape/sexual abuse
- \_\_\_\_\_ Other \_\_\_\_\_

**MENTAL / EMOTIONAL**

- \_\_\_\_\_ Nervousness
- \_\_\_\_\_ Anxiety
- \_\_\_\_\_ Panic attacks
- \_\_\_\_\_ Stress(describe)
- \_\_\_\_\_ \_\_\_\_\_
- \_\_\_\_\_ \_\_\_\_\_
- \_\_\_\_\_ Depression
- \_\_\_\_\_ Memory loss
- \_\_\_\_\_ Anger/irritability
- \_\_\_\_\_ Loss of zest for life
- \_\_\_\_\_ Low self esteem
- \_\_\_\_\_ Mood swings
- \_\_\_\_\_ Feeling overwhelmed
- \_\_\_\_\_ Suicidal thoughts or plans
- \_\_\_\_\_ Other \_\_\_\_\_

***Congratulations on completing your health history form. Now that you have had time to reflect on your health history, is there anything you may want to add for Dr. Walker's evaluation?***

**I declare that the medical history provided herein is accurate and complete, to the best of my recollection. If any other details come to mind at a later date I will inform Dr Walker immediately. I will not hold Dr Walker or Wellspring Chiropractic and Acupuncture Center responsible for any misdiagnosis made as a result of my providing inaccurate or incomplete information.**

**Signed \_\_\_\_\_ Date \_\_\_\_\_**

**Patient's Name \_\_\_\_\_**

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# **Wellspring Chiropractic and Acupuncture Center Financial Policy**

- We realize that health needs do not always coincide with financial means. When your treatment requires several visits, we will be happy to give you an estimate of the total treatment length and the approximate costs (Report of Findings). If you have a special situation or need, please let us know and we will tailor a payment plan designed for your unique circumstances. Please speak to the business manager. New patient visits must be paid in full.
  
- Assignment is not accepted for personal injury cases for new patients. You are expected to pay your fees, and collect reimbursement from your settlement. If you are an existing patient, we will be glad to review your case and determine what course of action would be best.
  
- We do not accept insurance assignment. We will file your insurance claim for you to your insurance company for reimbursement to you personally. We will make every effort to comply with your insurance carrier's requirements to obtain maximum reimbursement allowable.
  
- Payment expected at time services are rendered unless a signed financial agreement has been prepared in advance.
  
- All supplements and supplies must be paid for in full at the time they are dispensed. This is over and above any financial arrangement with the business office.
  
- Any appointments that are cancelled without 24 hours notice may be charged a \$25.00 missed appointment fee.
  
- Payment for services may be made by cash, check, Visa and MasterCard.

I HAVE READ THE ABOVE AND AGREE TO THESE FINANCIAL TERMS.

SIGNED \_\_\_\_\_

(Patient or Responsible Party)

DATE \_\_\_\_\_