

TOTAL HEALTH WELLNESS CENTER

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Chiropractic • Homeopathic • Acupuncture • Massage Therapy
In Yu, DAOM, LAc

Confidential Patient Health Record

Patient Name:	Date:
Who referred you to us?	File #
Marital Status: S M D W	Gender: M/F

Successful health care and preventative medicine are only possible when the Practitioner has a complete understanding of the Patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

When and where did you last receive health care? _____

For what reason? _____

Has your case been referred to an attorney? Yes No

Please identify the health concerns that have brought you to our clinic, in order of importance below:

	<u>Condition</u>	<u>Past Treatment</u>
1.	_____	_____
	How does this condition affect you? _____	
2.	_____	_____
	How does this condition affect you? _____	
3.	_____	_____
	How does this condition affect you? _____	
4.	_____	_____
	How does this condition affect you? _____	

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (include reaction)

Please list all medications (Prescribed or over-the-counter), vitamins and supplements you are currently taking

Do you have any reason to believe you may be pregnant? Yes No (if so, how far along?: _____)

Do you have any infectious diseases? Yes No if yes, please identify: _____

Family History	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Check the applicable						
Age (If living)	_____	_____	_____	_____	_____	_____
Health (G-good/P-poor)	_____	_____	_____	_____	_____	_____
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma/Hay fever/Hives						
Kidney Disease						
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

Height: _____ Weight: Currently: _____ Past Maximum: _____ When?: _____

Blood Pressure: What is your most recent blood pressure reading? _____/_____/_____ When taken? _____

Childhood Illness (Please check any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Immunizations (Please check any that you have had):

Polio Tetanus Rubella/Mumps Pertussis Diphtheria Hib Hepatitis B

Others: _____

Hospitalizations and Surgeries:

Reason When

Reason When

X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason When

Reason When

Please check any that you experience now and underline (after printing) any that you have experienced in the past:

Emotional Mood Swings Nervousness Mental Tension

Energy and Immunity Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

Respiratory

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough

Pleurisy Asthma Tuberculosis Shortness of Breath Other: _____

Cardiovascular

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Stroke

Palpitations/Fluttering Heart Murmurs Rheumatic Fever Varicose Veins

Gastrointestinal

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heart Burn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Genito-Urinary Tract

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

Female Reproductive/Breasts

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow Vaginal Discharge Clotting

Premenstrual Probs. Bleeding Between Cycles Menopausal Symptoms. Difficulty Conceiving Painful Periods

Menstrual/Birthing History

1. Age of First Menses: _____ 2. # of Days of Menses _____ 3. Length of Cycle _____

4. Birth Control Type: _____ 5. # of Pregnancies: _____ 6. # of Miscarriages: _____

7. # of Abortions: _____ 8. # of Live Births: _____

Male Reproductive Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Musculoskeletal

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?) _____

Neurologic

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Endocrine

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

Other Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

Lifestyle: Do you typically eat at least 3 meals per day? Yes No if no, how many? _____

Exercise Routine: _____

Spiritual Practice: _____ Reading Habits: _____

How many hrs per night do you sleep? _____ Do you wake rested? _____

Level of education completed? _____ Occupation: _____

Employer: _____ Hours/Week: _____

Do you enjoy work? Yes No Why/Why Not? _____

Nicotine/Alcohol/Caffeine Use: _____

Have you experienced any major traumas? Yes No Explain: _____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Hrs of Television/Day: _____ Interests/Hobbies: _____