WUNDERLICH CHIROPRACTIC

CONFIDENTIAL PATIENT HISTORY

WHAT BRINGS YOU IN TODAY?

PATIENT _____ DATE: _____

HEIGHT _____ WEIGHT _____ REFERRED BY _____

MAJOR COMPLAINT AND SYMPTOMS: _____

HOW DO YOU BELIEVE YOUR PROBLEM (PAIN) BEGAN? _____

WHEN DID YOU FIRST NOTICE THIS PROBLEM/PAIN? _____

HAVE POSITIONS OR ACTIVITIES AGGRAVATED YOUR CONDITION? _____

_____

WHAT POSITIONS OR ACTIVITIES RELIEVE YOUR CONDITION? _____

_____

HAVE YOU EVER BEEN TREATED BY A MEDICAL PHYSICIAN FOR THIS AILMENT? YES NO

IF YES, WHERE? _____

DESCRIBE THE TYPE OF TREATMENT _____

DIAGNOSIS OF PREVIOUS PHYSICIAN _____

LENGTH OF TIME UNDER CARE _____ RESULTS _____

GENERAL HEALTH QUESTIONNAIRE

DO YOU HAVE VERTIGO (DIZZINESS)?	YES NO
DO YOU PASS OUT EASILY (FAINT OR LOSS OF CONSCIOUSNESS)?	YES NO
DO YOU HAVE DOUBLE VISION OR HAVE YOU LOST SIGHT IN ONE EYE?	YES NO
DO YOU HAVE ANY SLURRED SPEECH OR DIFFICULTY WITH SPEECH?	YES NO
DO YOU HAVE INDIGESTION OR DIFFICULTY SWALLOWING?	YES NO
DO YOU HAVE ANY DIFFICULTY WALKING, WITH COORDINATION OR FALLING TO ONE SIDE?	YES NO
DO YOU HAVE NAUSEA OR VOMITING?	YES NO
DO YOU HAVE NUMBNESS ON ONE SIDE OF YOUR FACE OR BODY?	YES NO
DO YOU HAVE ANY VISUAL DISTURBANCES OR RAPID EYE MOVEMENT?	YES NO
DO YOU HAVE OR HAVE YOU EVER HAD DIFFICULTY IN ARRANGING WORDS PROPERLY?	YES NO
DO YOU HAVE A HEADACHE OR HEAD PAIN THAT IS UNLIKE ANY YOU HAVE HAD BEFORE?	YES NO
DO YOU HAVE HEADACHES FOR HOURS OR DAYS?	YES NO
DO YOU HAVE A HISTORY OF STROKE IN YOUR FAMILY?	YES NO
DO YOU HAVE CHEST PAIN?	YES NO
DO YOU HAVE A SORE THAT DOES NOT HEAL?	YES NO
DO YOU HAVE ANY UNUSUAL BLEEDING OR DISCHARGE?	YES NO
DO YOU HAVE A NAGGING COUGH OR HOARSENESS?	YES NO
DO YOU HAVE NIGHT SWEATS?	YES NO
DO YOU HAVE PAIN IN NECK, JAW OR FACE?	YES NO
DO YOU HAVE A DROOPING EYELID OR CHANGE IN YOUR PUPILS?	YES NO
DO YOU HAVE ANY RINGING IN YOUR EARS?	YES NO
HAVE YOU EVER HAD CANCER?	YES NO

Does your pain ever wake you from a sound sleep?	Yes No
Are you losing any weight now without trying?	Yes No
Have you had any loss of bladder or bowel control?	Yes No
Have you lost consciousness or had double vision recently?	Yes No
Do you take birth control pills?	Yes No
Are you taking any prescription medications? If yes, please list	Yes No
Are you taking herbs, supplements, botanicals, or vitamins? If yes, please list	Yes No
Are you taking any medication or over-the-counter drugs? (aspirin, etc.) If yes, Please list	Yes No
Are you seeing any other doctor now for any reason? If yes, please explain	Yes No
(Women only) Do you have any reason to believe that you may be pregnant?	Yes No

What operations have you had? Please include cosmetic surgery, Breast implants, etc.

_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____

SOCIAL HISTORY

Smoker? Yes No If yes, How many packs a day _____ Years_____

Alcohol? Yes No If yes, How much? _____ Years _____

FAMILY HISTORY

Did your mother or father have any of the following: Put an **M** for mother, **F** for father, and **B** for both.

_____High Blood Pressure
_____Heart Attack
_____Emphysema
_____Seizure-Convulsions
_____HIV Positive
_____Asthma
_____Diabetes
_____Kidney Disease
_____Ulcer or Stomach Problems
_____ Stroke (Please indicate age when stroke occurred, Mother_____Father _____
_____Arthritis- Rheumatism
_____Mental Illness
_____ Thyroid Disease
_____ Circulation Problems
_____ Cancer

Are you currently being treated or have you ever been treated for ANY condition not listed above? Please list the conditions and treatment:_____

_____

_____

Do you have any other problems or concerns you would like us to address?_____

_____

_____

Patient signature:_____ **Date:** _____