ABSOLUTE WELLNESS CENTER CONFIDENTIAL PATIENT HISTORY

NAME: ____ SS#: ___________________

ADDRESS: ______________________________CITY, STATE, ZIP: ____

PHONE NO: (w) ___________________________ (h) ________________________ (c)_______________________________

EMAIL____

BIRTHDATE: ________________ AGE: ________ GENDER: M F MARITAL STATUS: Sing. Mar. Div. Wid.

SPOUSE'S NAME: __________________________________ # OF CHILDREN: ___

THEIR NAMES: ____

EMPLOYER: ____________________________________JOB DESCRIPTION: ____

WHO IS RESPONSIBLE FOR YOUR ACCOUNT? _________________________ REFERRED BY: _______________________

What is your major complaint? ____

How long have you had this condition? ____________ Cause(if known): ____

Have you had this or similar conditions in the past? _________What aggravates your condition? _____________________________

Is this condition getting progressively worse? __ Yes __ No __ Constant __ Comes and Goes

Is this condition interfering with your __ work __ sleep __ daily routine __ other: __________________________________

Have you had any falls, accidents, or injuries? __ Yes __ No Describe: ____

Any known allergies? __ Yes __ No Describe: ____

Do you exercise regularly? __ Yes __ No Describe: ____

Do you have a daily bowel movement? __ Yes __ No If not, how often? ____

Please list any nutritional and/or herbal supplements you take:____

Have you had previous chiropractic care? __ Yes __ No Where:___________________Sleep Position: Back Side Stomach

Do you take any medications? ___ Yes ____ No If yes, what do you take?____

Have you had any surgeries? ____ Yes ____ No If yes, please explain ____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

___	Alcoholism	___	Cold Sores	___	Gout	___	Measles	___	Rheumatic Fever
___	Anemia	___	Diabetes	___	Heart Disease	___	Miscarriage	___	Scarlet Fever
___	Appendicitis	___	Diptheria	___	HIV Positive/AIDS	___	Multiple Sclerosis	___	Stroke
___	Arteriosclerosis	___	Eczema	___	Influenza	___	Mumps	___	Tuberculosis
___	Arthritis	___	Emphysema	___	Kidney Disease	___	Pleurisy	___	Typhoid Fever
___	Asthma	___	Epilepsy	___	Lumbago	___	Pneumonia	___	Ulcers
___	Cancer	___	Goiter	___	Malaria	___	Polio	___	Venereal Disease

FAMILY HEALTH INFORMATION

Relationship	Medical Problems
Mother	
Father	

Please check the appropriate box for any of the symptoms which you now have or you have had previously. **This is a confidential health report.**

"O" = Occasionally "F" = Frequently "C" = Constant

O	F	C	FOR WOMEN ONLY
			Cramps or Backache
			Excessive Menstrual Flow
			Irregular Cycle
			Menopausal Symptoms
			Painful Menstruation
			Vaginal Discharge

O	F	C	GENERAL
			Allergy
			Chills
			Convulsions
			Depression
			Dizziness
			Fainting
			Fatigue
			Fever
			Headache
			Nervousness
			Neuralgia
			Numbness
			Sleep Loss
			Sweats
			Tremors
			Weight Loss

O	F	C	MUSCLE & JOINT
			Arthritis
			Bursitis
			Foot Trouble
			Hernia
			Low Back Pain
			Lumbago
			Neck Pain
			Pain b/t Shoulders
			Pain or Numbness in:
			Shoulders
			Arms
			Elbows
			Hands
			Hips
			Legs
			Knees
			Feet
			Painful Tail Bone
			Poor Posture
			Sciatica
			Spinal Curvature
			Swollen Joints
			Weakness

O	F	C	GASTRO-INTESTINAL
			Abdominal Distention
			Belching
			Constipation
			Diarrhea
			Difficult Digestion
			Excessive Hunger
			Gall Bladder Trouble
			Hemorrhoids
			Intestinal Gas
			Jaundice
			Nausea
			Pain over Stomach
			Poor Appetite
			Vomiting
			Vomiting of Blood

O	F	C	EARS, EYES, NOSE & THROAT
			Asthma
			Crossed Eyes
			Deafness
			Dental Decay
			Earache
			Ear Discharge
			Ear Noises
			Enlarged Glands
			Enlarged Thyroid
			Eye Pain
			Failing Vision
			Far-Sightedness
			Frequent Colds
			Gum Trouble
			Hay Fever
			Hoarseness
			Near Sightedness
			Nosebleeds
			Sinus Infection
			Thyroid Problems
			Tonsillitis

O	F	C	CARDIOVASCULAR
			Hardening of Arteries
			High Blood Pressure
			Irregular Heartbeat
			Low Blood Pressure
			Pain Over Heart
			Poor Circulation
			Rapid Heartbeat
			Slow Heartbeat
			Swelling of Ankles

O	F	C	RESPIRATORY
			Chest Pain
			Chronic Cough
			Difficulty Breathing
			Coughing up Blood
			Coughing up Phlegm
			Wheezing

O	F	C	SKIN
			Body Acne
			Boils
			Bruise Easily
			Dryness
			Facial Acne
			Hives
			Itching
			Skin Eruptions
			Varicose Veins

O	F	C	GENITO-URINARY
			Bed Wetting
			Blood in Urine
			Frequent Urination
			Poor Bladder Control
			Kidney infection
			Kidney Stones
			Painful Urination
			Prostate Problems
			Sexual Problems

Please sign below that the information you have given is true and correct.

______________________________ ______________

Patient/Guardian Date