Fenske Holistic Healthcare Center LLC
(608) 836-8883

Patient Health History

Chiropractic

Name_____ **Date**_____

Date of Birth _____ **Age** _____ **Height** _____ **Weight** _____

Race/Ethnicity: ☐**Caucasian** ☐**African American** ☐**Asian** ☐**Hispanic** ☐**Native American** ☐**Other**

List your major concerns along with the cause(s) and what improves or aggravates them (if known or suspected). Also include prior treatments:

1. _____

_____

_____

_____

2. _____

_____

_____

Are your health concerns interfering with *(check all that apply)*:

☐ Work ☐ Daily Routine ☐ Sleep ☐ Other _____

Mark the table below with an 'X' in the appropriate box to indicate location, type and severity (for severity use a scale of 1 to 10 with 10 being the most severe pain).

	Pain: ache	**Pain: sharp**	**Pain: radiating**	**Pain: constant**	**Pain: intermittent**	**Tight-ness**	**Numb-ness**	**Severity (1-10)**
Head								
Neck								
Upper back								
L shoulder								
R shoulder								
Mid back								
Low back								
Abdomen								
L hip								
R hip								
L knee								
R knee								
L ankle								
R ankle								
L foot								
R foot								
Other								

Please list other practitioners seen for these concerns: (or check here for none: ☐)

Name Date (approx.) Testing/Treatment

1. _____

2. _____

Additional remarks about previous treatment:

_____

List all medications you are currently using, or have used recently. Include all over-the-counter medications. List dosages and approximate length of time you have used each medication:

_____

_____

_____

_____

List (include name, brand, dosage) all vitamins, minerals, herbs, and other natural products you are currently using:

_____

_____

_____

_____

List medication/supplement/environmental allergies or intolerances and associated reactions:

_____

_____

_____

_____

Illness / Conditions History

Please mark the appropriate box with an 'X' if these symptoms occur presently or have occurred in the past 6 months. Leave blank any spaces that do not apply.

GASTROINTESTINAL	**Yes**	**Past**
Irritable bowel syndrome		
GERD (reflux)		
Crohn's disease/ulcerative colitis		
Peptic ulcer disease		
Celiac disease		
Gallstones		
Other:_____		

RESPIRATORY	**Yes**	**Past**
Bronchitis		
Asthma		
Emphysema		
Pneumonia		
Sinusitis		
Sleep apnea		
Other: _____		

URINARY/GENITAL	Yes	Past
Kidney stones		
Gout		
Interstitial cystitis		
Frequent yeast infections		
Frequent urinary tract infections		
Sexual dysfunction		
Sexually transmitted diseases		
Other: _____		
ENDOCRINE/METABOLIC		
Diabetes		
Hypothyroidism (low thyroid)		
Hyperthyroidism (overactive thyr.)		
Polycystic Ovarian Syndrome		
Infertility		
Metabolic syndrome/insulin resist.		
Eating disorder		
Hypoglycemia		
Other: _____		
INFLAMMATORY/IMMUNE		
Rheumatoid arthritis		
Chronic fatigue syndrome		
Food allergies		
Environmental allergies		
Multiple chemical sensitivities		
Autoimmune disease		
Immune deficiency		
Mononucleosis		
Hepatitis		
Other: _____		
MUSCULOSKELETAL		
Fibromyalgia		
Osteoarthritis		
Chronic pain		
Other: _____		

SKIN	Yes	Past
Eczema		
Psoriasis		
Acne		
Skin cancer		
Other: _____		
CARDIOVASCULAR		
Angina		
Heart attack		
Heart failure		
Hypertension (high blood pressure)		
Stroke		
High blood fats (cholesterol, tri-glycerides)		
Rheumatic fever		
Arrythmia (irregular heart rate)		
Murmur		
Mitral valve prolapse		
Other: _____		
NEUROLOGIC/EMOTIONAL		
Epilepsy/Seizures		
ADD/ADHD		
Headaches		
Migraines		
Depression		
Anxiety		
Autism		
Multiple sclerosis		
Parkinson's disease		
Dementia		
Other: _____		
CANCER		
Lung		
Breast		
Colon		
Ovarian		
Skin		
Other: _____		

Surgical History

Please list all major and minor surgeries you have undergone with approximate dates:

_____

_____

_____

List Any Serious Accidents or Falls

_____

_____

Family Health History

Review the conditions below. Indicate if a family member has ever had a condition by marking the appropriate box with an 'X'. Leave blank any spaces that do not apply.

CONDITION **current age(s) >**	**Father**	**Mother**	**Spouse**	**Brother(s)**	**Sister(s)**	**Children**
Acne						
Alcoholism/addiction						
Allergies/hay fever						
Alzheimer's Disease / Dementia						
Arthritis						
Asthma						
Autoimmune disease						
Bedwetting						
Cancer (*specify type* _____)						
Depression						
Diabetes						
Digestive problems						
Ear infections						
Female problems						
Headaches						
Heart disease						
High blood pressure						
Insomnia						
Kidney problems						
Liver disease						
Mental health problems						
Migraine						
Muscle pain/cramps						
Osteoporosis						
Spinal curve						
Thyroid problems						
Other (*specify* _____)						
Other (*specify* _____)						
If any of the above family members are deceased, specify cause of death…						
…and list their age at death						
Other pertinent family history:						

Stress Factors

Please list any major stress factors in your life:

_____

_____

_____

Lifestyle/Diet Habits

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No
Describe your sleep pattern: Time arise _____ Time retire _____ Naps? ☐ Yes ☐ No
Your quality of sleep is: ☐ Well-rested ☐ Tired upon awakening ☐ Awaken during night
Do you: ☐ Sleep in total darkness ☐ Sleep near electric clock, outlet, or other electronic device
What is the frequency of your vacations: ____ times / year.
Do you exercise? ☐ Yes ☐ No
If *yes*… Type: _____ Frequency: ____ x per ☐ week / ☐ month (*check one*).
Do you use tobacco? ☐ Yes ☐ No If *yes*, list amount you smoke/chew per day or week _____
Years using tobacco _____, if you no longer use it, when did you quit _____
Do you use recreational drugs? ☐ Yes ☐ No
If *yes*, list type and frequency _____
Did you formerly use recreational drugs? ☐ Yes ☐ No If *yes*, specify _____
How frequently do you dine out: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely/never
How frequently do you eat fast food: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely/never
How much water do you drink daily: ☐ < 1 qt. ☐ 1 qt. ☐ 2 qt. ☐ > 2qt.
Is it filtered water? ☐ Yes ☐ No
Foods you avoid and why
(*i.e.* allergies, diet, dislike): _____
Foods you crave: _____
Do you have (or have you had) an eating disorder? ☐ Yes ☐ No
Do you drink coffee? ☐ Yes ☐ No
If *yes*, how many daily cups daily of decaf? _____ and caffeinated? _____
Do you drink tea? ☐ Yes ☐ No
If *yes*, what kind? _____ and how many cups do you drink daily? _____
Do you drink soda? ☐ Yes ☐ No
If *yes*, what kind? _____ and how many do you drink daily? _____
Do you drink alcohol? ☐ Yes ☐ No
If *yes*, list type and amount per day and week _____
Do you have (or have you had) a problem with alcohol or drug overuse? ☐ Yes ☐ No