COMPREHENSIVE HEALTH HISTORY

HUMBLE WELLNESS CLINIC
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THANK YOU FOR CHOOSING OUR OFFICE TO ASSIST YOU WITH YOUR HEALTH CARE. OUR ABILITY TO DRAW EFFECTIVE CONCLUSIONS ABOUT YOUR STATE OF HEALTH AND HOW TO OPTIMIZE ITS IMPROVEMENT DEPENDS LARGELY ON THE ACCURACY OF THE INFORMATION IN WHICH YOU PROVIDE, INCLUDING SYMPTOMS THAT YOU MAY CONSIDER MINOR. HEALTH ISSUES MAY BE INFLUENCED BY MANY FACTORS; THEREFORE, IT IS IMPORTANT THAT YOU CAREFULLY CONSIDER THE QUESTIONS ASKED IN THIS FORM AS WELL AS THOSE POSED BY THE DOCTOR DURING YOUR CONSULTATION. THIS WILL ASSIST OUR GOAL TO PROVIDE YOU WITH AN OPTIMAL PLAN OF HEALTH CARE, ENHANCE OUR EFFICIENCY, AND WILL PROVIDE EFFECTIVE USE OF YOUR SCHEDULED TIME.

DATE:_____

NAME:_____AGE:_____DATE OF BIRTH:_____M / F

ADDRESS:_____CITY/STATE:_____ZIP:_____

HOME PHONE: _____CELL PHONE:_____

EMAL:_____REFERRED BY:_____

SINGLE MARRIED DIVORCED WIDOWED PARTNERSHIP

OCCUPATION:_____NUMBER OF HOURS PER WEEK:_____

PLEASE DESCRIBE YOUR ACTIVITIES RELATING TO YOUR JOB (SITING AT A DESK, LIFTING, ETC.):_____

_____

GENETIC BACKGROUND (CAUCASIAN, HISPANIC, ETC.):_____

EMERGENCY CONTACT:_____PHONE NUMBER:_____

IF PATIENT IS A MINOR:

NAME OF GUARDIAN:_____ BIRTH DATE:_____ PHONE NUMBER:_____

ADDRESS:_____ CITY/STATE_____ZIP:_____

MEDICATIONS : PLEASE INCLUDE BOTH PRESCRIPTION AND NON-PRESCRIPTION

CURRENT MEDICATIONS	PURPOSE	HOW LONG?	DOSAGE	TAKEN DAILY?

LIST ANY MEDICATIONS YOU HAVE HAD A REACTION TO:_____

HOW OFTEN DO YOU HAVE TO TAKE AN ANTIBIOTIC?_____

Current Vitamins & Herbals	Purpose	How Long?	Dosage	Taken Daily?

List Any Medications, Vitamins, Herbals, Foods, Pollens, Danders, etc That Are Allergic To:_____

_____

Dental History

- ☐ Sore or Bleeding Gums
- ☐ Ringing in the Ears
- ☐ TMJ Problems
- ☐ Grinding At Night
- ☐ Bad Breath
- ☐ White Tongue
- ☐ Previous Braces
- ☐ Problems chewing

How Many Silver or Amalgam Fillings do you currently have?_____How Long?_____

How Many Of These Type of Fillings Have You Had Replaced With Composite or Some Other Material?_____

Are You Currently Seeing A Dentist or Orthodontist For A Particular Problem?_____

Have You Ever Had Any Dental Reconstructions Done?_____

Please List what a typical Breakfast, Lunch, and Dinner Is For You Including Snacks:

Breakfast	Snacks	Lunch	Snacks	Dinner

Do You Currently Follow A Nutritional Program?

- ☐ Low Carb
- ☐ Vegetarian
- ☐ Kosher
- ☐ Dairy-Free
- ☐ Blood Type Diet
- ☐ Diabetic
- ☐ Gluten-Free

I Feel **Worse** When You Eat A Lot Of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

I Feel **Better** When I Eat A Lot Of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Do You Crave Any Particular Foods?_____

BOWEL MOVEMENT HABITS

FREQUENCY	√	CONSISTENCY	√	COLOR	√
MORE THAN 3X/DAY		SOFT AND WELL FORMED		MEDIUM BROWN CONSISTENTLY	
1-3X/DAY		OFTEN FLOATS		VERY DARK OR BLACK	
4-6X/WEEK		DIFFICULT TO PASS		GREENISH COLOR	
2-3X/WEEK		DIARRHEA		BLOOD IS VISIBLE	
1 OR FEWER/WEEK		THIN, LONG, NARROW		VARIES A LOT	
		LOOSE BUT NOT WATERY		YELLOW, LIGHT BROWN	
		ALTERNATING HARD AND LOOSE		GREASY, SHINY APPEARANCE	

DO YOU CONSISTENTLY USE TOBACCO PRODUCTS? YES NO CIGARETTES ____CIGAR____PIPE____SMOKELESS____

HOW MUCH?_____HOW LONG?_____

ARE YOU EXPOSED TO 2ND HAND SMOKE REGULARLY? IF YES, PLEASE EXPLAIN_____

DO YOU DRINK ALCOHOL? YES NO WHAT KIND AND HOW OFTEN_____

DID YOU EVER HAVE A PROBLEM WITH ALCOHOL? WHEN?_____

DO YOU CURRENTLY USE RECREATIONAL DRUGS? YES NO WHAT TYPE?_____

HAVE YOU EVER USED RECREATIONAL DRUGS? YES NO WHAT TYPE?_____

DO YOU KNOW IF YOU HAVE EVER BEEN EXPOSED TO TOXIC METALS OR CHEMICALS (LEAD, MERCURY, ARSENIC, PESTICIDES, SOVENTS, ETC)? WHAT KIND?_____

ARE YOU SENSITIVE TO STRONG SMELLS SUCH AS PERFUMES OR HOUSEHOLD CLEANERS? YES NO SOMETIMES

AVERAGE NUMBER OF HOURS OF SLEEP PER NIGHT? _____

HOW WOULD YOU DESCRIBE YOUR SLEEP? GREAT GOOD OK POOR TERRIBLE

DO YOU

- ❑ HAVE TROUBLE FALLING ASLEEP?
- ❑ FEEL RESTED UPON WAKENING?
- ❑ HAVE PROBLEMS WITH INSOMNIA?
- ❑ SNORE?
- ❑ USE SLEEPING AIDS?

DO YOU WAKE UP AT A PARTICULAR HOUR OF THE NIGHT OFTEN? Y N WHAT TIME?_____

DO YOU EXERCISE? YES NO

IF YES, PLEASE INDICATE:	TIMES/WEEK				LENGTH OF SESSION (MIN.)			
TYPE OF EXERCISE	1X	2X	3X	4X/+	≤15	16-30	31-45	>45
JOGGING/WALKING								
AEROBICS								
STRENGTH TRAINING								
PILATES/YOGA/TAI CHI								
SPORTS (TENNIS, GOLF, WATER SPORTS, ETC)								
OTHER:								

IF YOU DO NOT EXERCISE, PLEASE EXPLAIN WHY_____

How well have things been going for you?	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With sex					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Please tell us about the health of your family members

Family Member	Major Ilnesses/Diseases Or Cause of Death
Mother	
Father	
Brothers	
Sisters	
Grandfathers	
Grandmothers	
Children	

Female Medical History

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies_____
- ❑ Caesarean _____
- ❑ Vaginal deliveries_____
- ❑ Miscarriage _____
- ❑ Abortion _____
- ❑ Living Children_____
- ❑ Post partum depression___
- ❑ Toxemia _____
- ❑ Gestational diabetes_____

Age at first menses?_____

Date of last menstrual period:____/____/_____

Average length of your cycle_____How many days do you menstruate_____

Circle all that apply to your menstrual cycles:

Painful Cramping Low back pain Breast Tenderness Irritable Cravings

Are you Currently using any of the following:

- ❑ Patch
- ❑ Birth control pills
- ❑ Nuva Ring
- ❑ Other (please describe)_____

EVEN IF YOU ARE *NOT* CURRENTLY USING CONCEPTION, BUT HAVE USED HORMONAL BIRTH CONTROL IN THE PAST, PLEASE INDICATE WHICH TYPE AND FOR HOW LONG._____

ARE YOU MENOPAUSAL? YES_____ NO_____ IF YES, AGE OF MENOPAUSE_____

DO YOU CURRENTLY TAKE HORMONE REPLACEMENT? YES_ NO_ IF YES, WHAT TYPE AND FOR HOW LONG?_____

❑ ESTROGEN ❑ OGEN ❑ ESTRACE ❑ PREMARIN ❑ PROGESTERONE ❑ PROVERA

❑ OTHER_____

DIAGNOSTIC TESTING

LAST PAP TEST:_____/_____/_____ NORMAL:_____ABNORMAL_____

LAST MAMMOGRAM_____/_____/_____ BREAST BIOPSY? DATE:_____/_____/_____

DATE OF LAST BONE DENSITIY_____/_____/_____ RESULTS: HIGH____ LOW____ WITHIN NORMAL RANGE____

IN ORDER TO IMPROVE YOUR HEALTH, HOW WILLING ARE YOU TO: **RATE ON A SCALE OF: 3 (VERY WILLING) TO 1 (NOT WILLING)**

MODIFY YOUR DIET	3 _____ 2 _____ 1 _____
TAKE NUTRITIONAL SUPPLEMENTS EACH DAY	3 _____ 2 _____ 1 _____
MODIFY YOUR LIFESTYLE (E.G. WORK DEMANDS, SLEEP HABITS)	3 _____ 2 _____ 1 _____
ENGAGE IN REGULAR EXERCISE	3 _____ 2 _____ 1 _____
HAVE PERIODIC LAB TESTS TO ASSESS PROGRESS	3 _____ 2 _____ 1 _____

AUTHORIZATION AND RELEASE

_____ I, THE UNDERSIGNED, CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT MY INSURANCE COMPANY PAYS THEM. I HEREBY AUTHORIZE HUMBLE WELLNESS TO RELEASE ANY AND ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I ALSO ACCEPT THE RESPONSIBILITY FOR ANY FEES ASSOCIATED WITH PROVIDING SUCH INFORMATION TO MY INSURANCE COMPANY. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY SCHEDULE OF CARE AS DETERMINED BY MY TREATING DOCTOR, ANY FEES FOR PROFESSIONAL SERVICES WILL BE IMMEDIATELY DUE AND PAYABLE.

WE WANT TO THANK YOU FOR CHOOSING US AS YOUR CHIROPRACTIC HEALTH PROVIDER. IN ORDER TO PROVIDE YOU AND OUR OTHER PATIENTS WITH THE MOST OPTIMAL CARE, WE REQUEST THAT YOU FOLLOW OUR GUIDELINES REGARDING BROKEN AND/OR CANCELLED APPOINTMENTS. PLEASE REMEMBER THAT WE HAVE RESERVED APPOINTMENT TIMES ESPECIALLY FOR YOU. THEREFORE, WE REQUEST AT LEAST 24-HOUR NOTICE IN ORDER TO RESCHEDULE YOUR APPOINTMENT. THIS WILL ENABLE US TO OFFER YOUR CANCELLED TIME TO OTHER PATIENTS.

_____**OUR OFFICE DOES RESERVE THE RIGHT TO CHARGE FOR CANCELLATION WITH LESS THAN 24 HOURS NOTICE AND BROKEN APPOINTMENTS. WE ALSO RESERVE THE RIGHT TO RETAIN AN ACTIVE CREDIT CARD ON HAND FOR SECURING RESERVED APPOINTMENTS.** THANK YOU FOR YOUR CONSIDERATION OF OUR POLICIES AND FOR THE OPPORTUNITY TO TAKE PART IN YOUR JOURNEY TOWARDS OPTIMAL HEALTH.

_____I UNDERSTAND AND AGREE TO ALLOW HUMBLE CHIROPRACTIC & KINESIOLOGY TO USE MY PATIENT HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, HEALTHCARE OPERATIONS, AND COORDINATION OF CARE.

IF YOU WOULD LIKE TO HAVE A MORE DETAILED ACCOUNT OF OUR POLICIES AND PROCEDURES CONCERNING THE PRIVACY OF YOUR PATIENT HEALTH INFORMATION, WE ENCOURAGE YOU TO READ THE HIPAA NOTICE ENTITLED *NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION* THAT IS AVAILABLE TO YOU AT THE FRONT DESK BEFORE SIGNING THIS CONSENT. IF THERE IS ANYONE YOU DO NOT WANT TO RECEIVE YOUR MEDICAL RECORDS, PLEASE INFORM US.

PATIENT / GUARDIAN SIGNATURE _____DATE _____