PATIENT HEALTH HISTORY
ROOTS WELLCARE, PA – Carla Breunig, DC, CCH

Name_____ **Date** _____

What are the reason(s) for your visit today?_____
_____
How do you hope your life will change as a result of working with us?_____
_____
What are the most significant changes you have made to improve your health?_____
_____

Health Concerns

What are your major health problems/concerns?

Date of onset_____Description_____
1._____
2._____
3._____
4._____
5._____
6._____

Describe the causes of these concerns (if known or suspected):_____
_____
_____

Have you had the same/similar problems before? Yes☐ No☐
What activities worsen your problem?_____
What activities improve your problem?_____
Are your problems getting progressively worse? Yes☐ No☐
Are your problems interfering with your: Work☐ Daily routine☐ Sleep☐ All☐
Other_____
If your condition involves pain, please characterize type:
Ache☐ Sharp☐ Radiating☐ Constant☐ Intermittent☐
Please rate the amount of pain you are generally experiencing (circle one):

Minor 1 2 3 4 5 6 7 8 9 10 *Severe*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Previous Treatment for Health Problems

None☐
Name of doctor/hospital:_____
Address:_____
Date first seen:_____Date last seen:_____
What tests were done, including x-rays?_____
Pertinent test results:_____
Condition or diagnosis:_____
How was the condition treated?_____
Results of treatment: Good☐ Fair☐ Poor☐

Please list below other doctors seen for this condition: None☐

Name Address Date Testing/treatment

1._____
2._____
3._____
4._____
5._____

Additional remarks about previous treatment:_____

_____

Current primary care physician:_____

Do you suffer from any other health problems for which you are NOT seeking consultation with us? Yes☐ No☐

If yes, please itemize below:

Doctor Condition Date of onset

1._____
2._____
3._____
4._____

Health Maintenance Update

Please indicate approximate dates and results of last:

Physical examination_____

Spinal examination_____

Dental examination_____

Dental X-ray_____

Cholesterol profile_____

Other blood tests (such as PSA(prostate))_____

Chest X-ray_____

Spinal X-ray_____

Bone Density (DEXA) Scan_____

Mammogram_____

Eye exam_____

Colonoscopy or flexible sigmoidoscopy_____

Other_____

Please itemize all medications you are currently using, or have used recently. Please be sure to include all over the counter medications and hormones, as well. List dosages and approximate length of time you have been on each medication.

Medication/hormone	Dosage/frequency	Length of time on this medication

List names, brands and dosages of all vitamins, minerals, herbs, and other natural products you are currently using:

Vitamin/Mineral/Herb/Other Product	Brand	Dosage/frequency

Please list medication, supplement, environmental allergies or intolerances and the reactions you have experienced to them:_____
_____
_____
_____
_____

Please list past or present exposure to harmful chemicals:_____
_____
_____

Surgical History

Please chronologically indicate all major and minor surgeries you have undergone and their approximate dates:

Surgery: major or minor	Approximate Date

Previous Chiropractic Care

None☐
Name of Chiropractor:_____
Address:_____
Dates of treatment: First treatment:_____Last treatment:_____
Under treatment for what condition at that time?_____
Were X-rays performed? If so, please indicate approximate date and area_____
_____
Cause of trouble as explained by doctor:_____
Results of treatment: Good☐ Fair☐ Poor☐

Previous Homeopathic Care

None☐
Name of previous Homeopath:_____
Address:_____
Dates of treatment: First treatment:_____Last treatment:_____
Under treatment for what condition at that time?_____
Remedies given, if you remember:_____
Results of treatment: Good☐ Fair☐ Poor☐

Serious Accidents and Falls

Have you ever been in an auto accident? No☐ Yes☐ Date_____
Describe:_____
Have you had any sports injuries? No☐ Yes☐ Date_____
_____
Have you had any work accidents? No☐ Yes☐ Date_____
Describe_____
Please describe any other falls, accidents, or injuries and indicate dates:_____
_____
_____
Please list all fractures you have sustained and when they occurred:_____
_____

Early Health History

Did your mother have any known problems during her pregnancy with you (illness, stress, medication, smoking, alcohol, traumatic delivery)?_____
_____
Were you breastfed or bottlefed? If breastfed, please indicate duration_____
_____
Was your home life during childhood and adolescence loving and supportive, or were there significant stresses?
_____
Please check if you had any of the following childhood illnesses:
Frequent ear infections☐ Colic☐ Eczema☐ Recurrent colds☐ Bronchitis☐ Pneumonia☐ Meningitis☐
Were you on frequent or prolonged antibiotic therapy?_____
Did you receive standard immunizations?_____
Did you experience any adverse reactions to immunizations?_____
_____

Please check if you have had any of the following conditions:

☐Flu
☐Allergies
☐Alcohol/drug addiction
☐Anemia
☐Asthma
☐Cancer
☐Chicken Pox
☐Diabetes
☐Emphysema
☐Epilepsy
☐Polio
☐Psoriasis
☐Heart attack
☐Heart disease
☐High blood pressure
☐Kidney disease
☐Measles
☐Mental health problem
☐Mumps
☐Pleurisy
☐Pneumonia
☐HIV+/AIDS
☐Rheumatic fever
☐Rheumatoid arthritis
☐Sexually transmitted infection_____
☐Thyroid disorder
☐Tuberculosis
☐Ulcer
☐Whooping cough
☐Other: describe, _____

Female Health History

Age at first period:___Date of last period:_____ # pregnancies:___# live births:____
Date of last Pap test:_____ History of abnormal Pap tests? Yes___ No___
History of irregular periods? Yes___ No___ Menstrual cycle length:____days
Duration of menstrual period:___days
Do you experience significant menstrual cramping? Yes___ No___
Is heavy bleeding a problem? Yes___ No___
Do you have a history of endometriosis? Yes___ No___
Do you have a history of infertility? Yes___ No___
Do you have excessive unwanted hair growth? Yes___ No___
Do you have a tendency toward premenstrual syndrome? No___ Yes___
(please describe symptoms)_____
Do you have a family history of:
Breast cancer Yes___ No___
Ovarian cancer Yes___ No___
Osteoporosis Yes___ No___
Describe any current menstrual or menopausal symptoms or concerns:_____
_____
Describe any current breast problems:_____
Did you breast feed?____ Please indicate duration for each child:_____

Digestive Function

Describe any food intolerances:_____
Describe any digestive problems:_____
_____
_____
Bowel movement frequency: _____
Do you usually have to strain to have a bowel movement? Yes___ No___
Do you ever have blood with bowel movements? Yes___ No___
Are your stools ever black or tarry? Yes___ No___
Last time you received antibiotics:_____

Diet History

Typical breakfast:_____
Typical lunch:_____
Typical dinner:_____
Typical snacks:_____
Frequency of dining out:_____ Frequency of eating fast food:_____
Quantity of water consumed/day:_____Is you water filtered? Yes___ No___
Foods you avoid:_____
Foods you crave:_____
History of eating disorder? Yes___ No___

Lifestyle Habits

Please check major stresses:
Job___ New retirement___ New baby___ Change of marital status___ Health problems___
Family stress___ Financial concerns___Abusive relationship___Death of loved one/pet___ Other___
Please describe:_____
_____
Please describe the quality of major relationships in your life_____
_____
Please indicate job satisfaction: Excellent___ Good___ Fair___ Poor___

Lifestyle Habits (continued)

Sleep: Time arise:_____ Time retire:_____ Naps:_____
Quality of sleep: Well-rested☐ Tired upon awakening☐ Awaken during night☐
Sleep in total darkness_____ Sleep with some light in room_____
Frequency of vacations:_____/year
Travel frequency:_____
Have you experienced physical, emotional, sexual, or verbal abuse? Yes☐ No☐
Exercise: None☐ Type_____ Frequency_____
How do your relax or relieve stress?_____
_____
Coffee (amount/day):_____
Tea (amount/day):_____
Soda pop (amount/day):_____
Liquor: None☐ Type and amount per day and week:_____
Present or former history of alcohol overuse? Yes☐ No☐
Tobacco: None☐ Chew or smoke and amount per day:_____
Number of years using tobacco:_____Date(s) quit:_____
Recreational drug use: None____ Type and frequency_____
Former history of recreational drug use? No☐ Yes☐ Please specify_____

Family Health History

Please review the conditions listed below. Indicate those that are current health problems of a family member by writing the letter **C** under his/her column. Use a letter **P** to indicate a past problem. Spaces that do not apply should be left blank. If adopted and history unknown, check here: _____.

Condition	**Father Age ____**	**Mother Age ____**	**Spouse Age ___ _____**	**Brother/s Ages____**	**Sister/s Ages _____**	**Children Ages _____**
Alcoholism/Addiction						
Alzheimer's Disease						
Allergies/hay fever						
Arthritis						
Asthma						
Cancer (indicate type)						
Depression						
Diabetes						
Digestive problems						
Heart disease						
High blood pressure						
Insomnia						
Kidney problems						
Liver disease						
Mental health problems						
Migraine						
Osteoporosis						
Other (indicate)						
Other (indicate)						

If any of the above family members are deceased, please list their age at death and cause:_____
_____

MEDICAL SYMPTOMS QUESTIONNAIRE

Rate each symptom based upon your health profile for the past 30 days.. POINT SCALE BELOW:

0=**Never** or **almost never** have the symptom
1=Occasionally have it; effect is **not severe**
2=Occasionally have it; effect is **severe**
3=Frequently have it; effect is **not severe**
4=Frequently have it; effect is **severe**

DIGESTIVE FUNCTION
___Nausea or vomiting
___Constipation
___Belching/passing gas
___Bloating
___Heartburn
___Diarrhea

JOINTS/MUSCLES
___Pain or aches in joints
___Arthritis/swelling of joints
___Stiffness/limitation of movement
___Pain or aches in muscles
___Weakness or muscle fatigue

MOUTH/THROAT
___Chronic coughing
___Gagging, frequently clearing throat
___Sore throat, hoarse, loss of voice
___Swollen/discolored tongue, gums, lips
___Canker sores

EARS
___Itchy ears
___Earaches/infections
___Ringing in ears/hearing loss
___Drainage from ear

HEAD
___Headaches
___Faintness
___Dizziness
___Insomnia

MENTAL & NEUROLOGIC FUNCTION
___Poor memory
___Confusion, poor comprehension
___Poor concentration
___Poor physical coordination
___Difficulty making decisions
___Stuttering or stammering
___Slurred speech
___Learning disabilities

WEIGHT
___Binge eating or drinking
___Craving certain foods
___Excessive weight
___Compulsive eating
___Water retention
___Underweight

SKIN
___Acne
___Hives
___Hair loss
___Flushing or hot flashes
___Excessive sweating

NOSE
___Stuffy nose
___Sinus problems
___Hay fever
___Sneezing attacks
___Excessive mucous formation

EMOTIONS
___Mood swings
___Anxiety, fear, nervousness
___Anger, irritability, aggression
___Extreme sadness that does not go away

LUNGS
___Chest congestion
___Asthma, bronchitis
___Shortness of breath
___Easily winded

HEART
___Irregular or skipped heartbeat
___Rapid or pounding heartbeat
___Chest pain

OTHER
___Genital itch or discharge
___Frequent illnesses
___Frequent or urgent urination
___Loss of bladder control

PATIENT NAME:_____**DATE:**_____