arise
VERNON'S WELLNESS HEADQUARTERS

HEALTH HISTORY

Reasons for your visit: (Please list in order of priority)

1) _____ 3) _____

2) _____ 4) _____

How long have you had this problem? _____ How did it occur? _____

_____

Did the problem occur [ ] immediately [ ] gradually. Did this ever happen before? [ ]Yes [ ] No.

If yes, when? _____

What, if any, treatment did you receive? _____

The problem: [ ] Comes and Goes [ ] Is Constant

The problem seems to be : [ ] Getting Better [ ] Getting Worse [ ] Remaining the Same

What makes it better? _____What makes it worse? _____

Have you seen a medical doctor about this problem? [ ] Yes [ ] No. Dr.'s Name: _____

When?_____ What treatment was given? _____

Have you tried home remedies? [ ] Yes [ ] No.

If yes, please describe:_____

Have the home remedies helped? [ ] Yes [ ] No.

Have you ever had chiropractic care? [] Yes [] No. If yes, Dr.'s Name:_____

When was your last visit?_____ Reason for visit?_____

Do you sleep on your: [ ] Back [ ] Side [ ] Stomach

Are you on any medication? [ ] Yes [ ] No. If yes, please list:_____

_____

Please list any surgeries you have had: _____

Have you had any accidents or injuries? Please describe: _____

****

DOCTOR'S NOTES:

_____

_____

_____Date:_____

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD:

MUSCULOSKELETAL
[ ] Arthritis
[ ] Low Back Pain
[ ] Pain Between Shoulders
[ ] Neck Pain
[ ] Arm Pain
[ ] Walking Problems
[ ] Jaw Problems

NERVOUS SYSTEM CODE
[ ] Numbness
[ ] Epilepsy
[ ] Paralysis
[ ] Dizziness
[ ] Forgetfulness/Confusion
[ ] Depression
[ ] Mental Disorder
[ ] Fainting
[ ] Convulsions
[ ] Cold/Tingling Extremities

GENERAL CODE
[ ] Allergies
[ ] Loss of Sleep
[ ] Fever
[ ] Headaches

GENITO-URINARY CODE
[ ] Discoloured Urine
[ ] Bladder Trouble
[ ] Painful/Excessive Urination

C-V-R CODE
[ ] Smoke Cigarettes
[ ] Lung Problems
[ ] Asthma
[ ] Irregular Heartbeat
[ ] Diabetes
[ ] Chest Pain
[ ] Short Breath
[ ] Ankle Swelling
[ ] Varicose Veins
[ ] Stroke
[ ] Heart Attack
[ ] High Blood Pressure

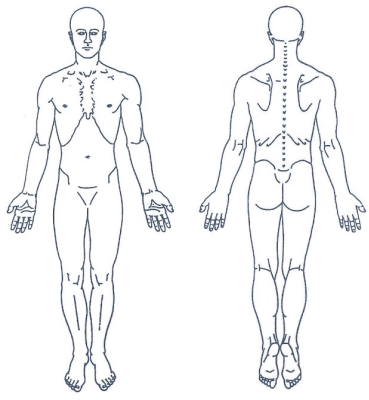
EENT CODE
[ ] Stuffed Nose
[ ] Vision Problems
[ ] Dental Problems
[ ] Sore Throat
[ ] Ear Aches
[ ] Hearing Difficulty

GASTRO-INTESINAL CODE
[ ] Excessive Thirst
[ ] Frequent Nausea
[ ] Colitis
[ ] Crohns
[ ] Vomiting
[ ] Diarrhea
[ ] Constipation
[ ] Hemorrhoids
[ ] Weight Trouble
[ ] Abdominal Cramps
[ ] Poor/Excessive Appetite
[ ] Gas/Bloating After Meals

MALE / FEMALE CODE
[ ] Menstrual Irregularity
[ ] Menstrual Cramping
[ ] Vaginal Pain/Infections
[ ] Breast Pain/Lumps
[ ] Prostate/Sexual Dysfunction

FEMALES ONLY:
When was your last period?_____
Are you pregnant? [ ] Yes
[ ] No
[ ] Maybe

SHOW US WHERE IT HURTS



OTHER CONDITIONS

[ ] AIDS
[ ] Scarlet Fever
[ ] Diphtheria
[ ] Typhoid Fever
[ ] Pneumonia
[ ] Alcoholism
[ ] Eczema
[ ] Venereal Infection
[ ] Small Pox
[ ] Anemia
[ ] Cancer
[ ] Thyroid
[ ] Liver Trouble
[ ] Gall Bladder
[ ] Rheumatic Fever
[ ] Polio
[ ] Malaria
[ ] Tuberculosis
[ ] Whooping Cough

List any other conditions or problems you feel may be important:_____

_____

Date_____