

<i>Feel Awesome</i> Wellness Center LLC	
<i>Discover Transform Awaken</i>	
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CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name _____ Date _____

CHIROPRACTIC AND HEALTH CARE HISTORY

Have you seen a chiropractor before? Y N

Have you seen a *NETWORK* chiropractor before? Y N If so, who? _____

Are you currently seeing a chiropractor? Y N

Previous DCs name _____ Current DCs name _____

When was your last visit? _____ If you stopped going, why? _____

Were you pleased with their service? _____

Does your immediate family currently receive chiropractic care? Y N

Do you see any other health professional for any reason? Y N Who and why? _____

Have you ever used any of the following approaches towards health, growth and development?

If so, please list with any comments you wish to share:

Bodywork / Massage _____

Accupuncture _____

Detox / Cleanses _____

Meditation _____

Psychotherapy _____

Yoga _____

Nutritional Counselling _____

Rebirthing/Breathwork _____

Prayer _____

Other _____

What diagnosis and treatments have you had? _____

Have you had any X-rays in the past 5 years? Y N Please explain _____

Have you had, or do you have, any health problems or illness? Y N Please explain _____

Do you have a family history of health problems or illness? Y N Please explain _____

How important is your health to you? Extremely Very Somewhat Minimally Not

What do you do to maintain good health? _____

Do you eat a healthy diet? Y N Describe _____

My typical breakfast: _____

My typical lunch: _____

My typical dinner: _____

My typical snacks: _____

I typically drink how much water daily: _____

I eat raw fruit multiple times a day Y N Describe _____

I eat raw vegetables multiple times a day Y N Describe _____

I take/eat high quality raw oils (ex. Fish, flax, olive, coconut etc.) Y N

Describe what / quantity: _____

Do you take vitamins / minerals? Y N Describe _____

I joyfully exercise for fun and health (not for work) at least 30 minutes:

_____ Daily _____ 3x/Wk _____ 2x/Wk _____ 1x/Wk _____ 2x/Month _____ Rarely

Explain how you like to exercise: _____

What do you do for fun / hobbies? _____

Do you sleep well? Y N Describe _____

Is your bowel elimination / intestinal health normal? Y N Please explain _____

Bowel movements per day? _____

Do you take extra fiber? Y N Describe _____

Do you take intestinal bacteria? Y N Describe _____

Do you take / eat anything else for your health? Y N Describe _____

PHYSICAL STRESSES

Was your mother outwardly ill prior or during her pregnancy with you? Y N

Did your mother have a difficult pregnancy with you? Y N

Did your mother have any falls or physical injury during her pregnancy with you? Y N

Was your delivery traumatic? Y N

Drug induced Y N C-section Y N Breech Y N

Forceps or Suction Y N Cord around neck Y N Prolonged Y N

Other _____

Did you have any significant injuries as a child (ex. fall out of crib)? Y N Describe _____

Have you as a driver or passenger ever been involved in a motor vehicle accident *or near accident*?

Y N When? _____ Describe _____ mild / mod / severe

When? _____ Describe _____ mild / mod / severe

Have you been involved in any other type of moving vehicle accident or near accident such as:

Bicycle, motorcycle, bus, train, airplane, moped, etc.

Y N When? _____ Describe _____ mild / mod / severe

Have you ever fractured or broken any bones? Y N

When? _____ Describe _____

When? _____ Describe _____

Have you experienced any other major falls, accidents or trauma *at any time*? Y N

When? _____ Describe _____ mild / mod / severe

When? _____ Describe _____ mild / mod / severe

Have you ever been knocked unconscious? Y N Describe _____

Have you ever had surgery or been hospitalised? Y N

When? _____ Describe _____

When? _____ Describe _____

Have you had:

Spinal tap Y N Spinal injections Y N Physiotherapy Y N

Neck collar Y N Spinal brace Y N Traction Y N

Heel lift Y N MRI Y N CT Scan Y N

Corrective shoes Y N Arch supports Y N Transfusion Y N
Bone in case Y N If yes, please describe _____

Have you had any body part removed? Y N Describe _____

Have you ever used crutches a walker or a cane? Y N Describe _____

Have you had extensive dental work? Y N Describe _____

Are you or have you been involved in sport or physical activities? Y N Describe _____

Have you been injured in any of these activities? Y N Describe _____

Please describe your current daily activities by noting how many hours / day you do the following:

_____sitting _____stand _____walk _____computer _____drive
_____desk work _____reading _____cell phone _____land phone _____physical work
_____heavy lifting _____ watching TV _____OTHER _____

Do you use corrective eyewear? Y N I use: Glasses Contacts Bifocals

Have you had corrective eye surgery? Y N Date & describe _____

Do you play a musical instrument? Y N If yes, have you experienced repetitive use injury? Y N
Describe _____

Have you experienced anything else that you consider may have been stressful *in any way*? Y N

Please explain _____

CHEMICAL STRESSES

Have you ever worked with any chemical, fume, dust, powder or smoke for prolonged periods? Y N
Please explain _____

Have you ever smoked? Y N How much, when & how long? _____

Do you drink alcohol? Y N How much, how often? _____

Do you drink any caffeine products? What, how often? _____

Do you use sugar /eat sugar products? Describe _____

Do you drink sodas? Y N Describe _____

Use artificial sweeteners? Y N Describe _____

Are you presently taking any drugs (prescription or over-the-counter)? Y N

Please explain _____

Please list *all* medications (prescribed and over the counter) that you are or have taken:

Drug	Taken For	Amount	Dates

Are these drugs prescribed by a medical doctor? Y N Last MD visit _____

Have you had chemo or radiation therapy? Please explain _____

Have you had any amalgam fillings removed? Y N When, which ones _____

Any other toxic exposure that you'd like to share? _____

MENTAL – EMOTIONAL STRESSES

<u>Present or Past</u>	<u>Describe including Dates</u>
Work or school stress Y N mild moderate extreme	_____
Family or home stress Y N mild moderate extreme	_____
Personal relationships Y N mild moderate extreme	_____
Loss of loved one Y N mild moderate extreme	_____
Lifestyle changes Y N mild moderate extreme	_____
Childhood stress Y N mild moderate extreme	_____
Other _____ Y N mild moderate extreme	_____

Rate your physical health? Excellent good fair poor improving same worsening

Rate your mental-emotional health? Excellent good fair poor improving same worsening

Is there anything else at all that you would like us to know? _____
