

**All American Wellness Center**

**Confidential Patient Health Record**

|      |          |
|------|----------|
| DATE | I.D. NO. |
|------|----------|

**PERSONAL HISTORY**

Name: \_\_\_\_\_

City: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Social Insurance #: \_\_\_\_\_

Business Employer: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Type of Work: \_\_\_\_\_

Referred to this office By: \_\_\_\_\_

Name and Number of Emergency Contact: \_\_\_\_\_

Address: \_\_\_\_\_

State/Prov: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

E-mail: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_

Circle One: Married Single Widowed Divorced Separated

Type of Work: \_\_\_\_\_

Spouse's Social Security #: \_\_\_\_\_

Spouse's Social Insurance #: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Names and Ages of Children: \_\_\_\_\_

Relationship: \_\_\_\_\_

Who is responsible for your bill, You and  Spouse  Worker's Comp.  Auto Insurance  Medicare  Medicaid

Personal Health Insurance (Name) \_\_\_\_\_  Health Card #: \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Purpose of this appointment: \_\_\_\_\_

Others Doctors seen for this condition:  Yes  No Who? \_\_\_\_\_

Type of treatment: \_\_\_\_\_ Results: \_\_\_\_\_

When did this condition begin: \_\_\_\_\_ Has this condition occurred before?  Yes  No

Is condition:  Job Related  Auto Accident  Home Injury  Fall  Other: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Have you made a report of your accident to your employer:  Yes  No

Drugs you now take:  Nerve Pills  Pain Killers/Muscle Relaxers  Blood Pressure Medicine

Insulin  Other: \_\_\_\_\_

Do you wear a shoe lift?  Yes  No

Do you suffer from any condition other than that which you are now consulting us? \_\_\_\_\_

**PAST HEALTH HISTORY**

Please check and describe: \_\_\_\_\_

Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  Back Surgery

Broken Bones  Other \_\_\_\_\_

Major Falls: \_\_\_\_\_

Hospitalization (Other than above): \_\_\_\_\_

Previous Chiropractic Care:  None  Doctor's name & Approximate date of last visit: \_\_\_\_\_

# Pertinent Patient History

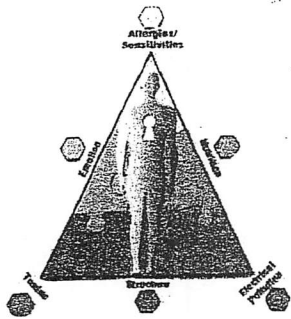
Patient's Name

Age

Date

A. Please complete the following with the appropriate age of occurrence

| SURGERY  | Age | <b>SERIOUS INFECTIONS/DISEASES</b><br>(pneumonia, mono, cancer, heart attach, chronic bronchitis, colitis, measles, chicken pox, etc.) | Age | <b>DENTAL INTERVENTION</b><br>(Root canals & extractions, age of first silver anagam filling, braces, retainer, etc.) | Age |
|--|-----|--|-----|---|-----|
|  |     |  |     |   |     |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
|  |     | Typical childhood vaccinations? Yes___No___  |     |   |     |
| Toxic Profession Past Or Present<br>(artist, graphic designer, dentist, dental assistant, gas station worker, painter, industry, etc.) | Age | Long periods on prescription or street drugs, alcohol or cigarettes  | Age |   |     |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
| Injuries/Accidents without stitches  | Age | Injuries/Accidents With stitches   | Age | Pregnancies/births, abortions/IUD's, B.C. pills, etc.   | Age |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
| Major Psychological Trauma   | Age | Long visits or loved in a foreign country like India, Mexico, Africa, etc.   | Age | Medications/Allergies (past or present)   | Age |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
|  |     |  |     |   |     |
|  |     | Tested for parasites, infection? Yes___No___   |     |   |     |



## BIOTOXICITY SYMPTOM QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile:

### Point Scale

- 0 – Never or almost never have the symptoms
- 1 – Occasionally has it, effect is not severe
- 2 – Occasionally has it, effect is severe
- 3 – Frequently has it, effect is not severe
- 4 – Frequently has it, effect is severe

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 10 or more, or the grand total is 50 or more, you may benefit from a detoxification program.

#### DIGESTIVE

- Nausea or vomiting
- Diarrhea
- Constipation
- Bloating feeling
- Belching, passing gas
- Heartburn
- TOTAL

#### EMOTIONS

- Mood swings
- Anxiety, fear, nervous
- Anger, irritability
- Depression
- TOTAL

#### EYES

- Watery, itchy eyes
- Swollen, reddened or sticky eyelids
- Dark circles under eyes
- Blurred/tunnel vision
- TOTAL

#### LUNGS

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficulty breathing
- TOTAL

#### EARS

- Itchy ears
- Earaches, ear infection
- Drainage from ear
- Ringing in ears, hearing loss
- TOTAL

#### ENERGY/ACTIVITY

- Fatigue, sluggishness
- Apathy, sluggishness
- Hyperactivity
- Restlessness
- TOTAL

#### HEAD

- Headaches
- Faintness
- Dizziness
- Insomnia
- TOTAL

#### MIND

- Poor memory
- Confusion
- Poor concentration
- Poor coordination
- Difficulty making decisions
- Stuttering, stammering
- Slurred speech
- Learning disabilities
- TOTAL

#### MOUTH/THROAT

- Chronic coughing
- Gagging, need to clear throat
- Sore throat, hoarse
- Swollen or discolored tongue, gums, lips
- Canker sores
- TOTAL

#### SKIN

- Acne
- Hives, rashes, dry skin
- Hair loss
- Flushing or hot flashes
- Excessive sweating
- TOTAL

#### JOINT/MUSCLES

- Pain or aches in joints
- Arthritis
- Stiff, limited movement
- Pain, aches in muscles
- Weakness or tiredness
- TOTAL

#### NOSE

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus
- TOTAL

#### HEART

- Skipped heartbeats
- Rapid heartbeats
- Chest pain
- TOTAL

#### WEIGHT

- Binge eating/drinking
- Craving certain foods
- Excessive weight gain
- Compulsive eating
- Water retention
- Underweight
- TOTAL

#### OTHER

- Frequent illness -
- Frequent/urgent urination
- Genital itch, discharge
- TOTAL

**GRAND TOTAL**