Therapia
WELLNESS CLINIC

Seth Means, DC
Tax ID 45-3579099
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New Patient Health History Form

Patient Data
First Name_________________________ Last Name_________________________ Date_____________________ Name you prefer to be called (if different from above):____ E-mail address____ How did you hear about us?____ Who can we thank for referring you?____

Mailing Address
Address__________________________________ City_____________________ State______ Zip_____________ Phone (Home)________________________ Work________________________ Cell__________________________ Age____ Birth Date_________________ SSN#_______________________ Number of Children ____________ Occupation___________________________________ Employer____ Marital Status____________ Emergency Contact______________________________ Phone__________________

Medical History
Have you been treated for any conditions in the last year? __No __Yes If yes, please describe____ Date of last physical exam_____________________________ Is there a chance that you are pregnant? __No __Yes Have you had X-rays taken? __No __Yes If yes, where?____ What medications are you taking and for what conditions (Please list dosage and amounts, etc.) ____ What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency)

Have you ever:	**No**	**Yes**	**Briefly explain**
Broken bones?	___	___	
Been hospitalized?	___	___	
Been in an auto accident?	___	___	
Had sprains/strains?	___	___	
Had surgery?	___	___	
Do you have a pacemaker?	___	___	

Family History
Family Members – Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc)

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Name:____________________________________ DOB:___________________ Date:_______________

Current Complaints
Nature of Injury ___Automobile* ___Work ___Other Please describe:____ ____ What are you concerned about today?____ ____ ____ Date of Injury ________________ Date symptoms appeared________________ Have you ever had same condition? ___No ___Yes If yes, when? ______________________________________ List of other practitioners seen for this injury/condition____ Have you ever been under chiropractic care? ___No ___Yes Have you ever received acupuncture? ___No___Yes If yes, please describe____ Do you experience pain every day? __No __Yes Do your symptoms interfere with daily life? __No __Yes Explain_____________________________________ Does pain wake you up at night? __No __Yes Are your symptoms worse during certain times of the day? __No __Yes Explain___________________________ Do changes in weather affect your symptoms? __No __Yes

TELL US WHERE YOU'RE HURT:

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL PAIN. IF YOUR PAIN RADIATES, DRAW AN ARROW FROM WHERE IT STARTS TO WHERE IT STOPS. USE THE SYMBOLS LISTED BELOW.

ACHE >>>> BURNING XXXX NUMBNESS ====

STABBING //// PINS/NEEDLES 0000 THROBBING ~~~~

HOW OFTEN ARE YOUR SYMPTOMS PRESENT?

(PLEASE CIRCLE)

0-25% 26-50% 51-75% 76-100%

IN THE PAST WEEK, HOW MUCH HAS YOUR PAIN INTERFEREDWITH YOUR DAILY ACTIVITIES?

0 1 2 3 4 5 6 7 8 9 10
no interference unable to carry out activities

SYMPTOM RATING SCALE

INSTRUCTIONS: Please circle the number that best describes your symptoms in each of the questions below.

WHAT IS YOUR SYMPTOM INTENSITY RIGHT NOW?
0 1 2 3 4 5 6 7 8 9 10
no symptoms unbearable symptoms

WHAT IS YOUR TYPICAL SYMPTOM INTENSITY?
0 1 2 3 4 5 6 7 8 9 10
no symptoms unbearable symptoms

WHAT IS YOUR SYMPTOM INTENSITY AT ITS WORST?
0 1 2 3 4 5 6 7 8 9 10
no symptoms unbearable symptoms

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Name:______________________________ DOB:________________ Date:______________

Health Problems and Concerns: Please circle and indicate if you have experienced any of the following, add "C" if currently experiencing the issue:

Allergies	Digestion Problems	Nosebleeds
Alcoholism	Dizziness	Polio
Anemia	Excessive Menstruation	Poor Posture
Arteriosclerosis	Eye Pain	Prostate Trouble
Arthritis	Fatigue	Sciatica
Asthma	Frequent Urination	Shortness of Breath
Back Pain	Headache	Sinus Infection
Breast Lump	Hemorrhoids	Sleep Problems
Bronchitis	High Blood Pressure	Spinal Curvatures
Bruise Easily	Hot Flashes	Stroke
Cancer	Irregular Heart Beat	Swelling of Ankles
Chest Pain	Irregular Menstrual Cycle	Swollen Joints
Cold Extremities	Kidney Infection	Thyroid Condition
Constipation	Kidney Stones	Tuberculosis
Cramps	Loss of Memory	Ulcers
Depression	Loss of Balance	Varicose Veins
Diabetes	Loss of Smell	Venereal Disease

Life Choices
(Please circle)

Exercise: Type_____________________ Frequency____________________

Alcohol: Beer Wine Liquor ______ times a week/month

Tobacco: Cigarettes Chew Pipe ______ a day for _____years

Caffeine: Daily Weekly Occasionally Never