# Wilke Chiropractic & Wellness
# Comprehensive Health Profile

**Name:_____ Today's Date: _____/_____/_____**

**Date of Birth: _____/_____/_____**

How did you discover our office? _____

*Please complete this general health history survey, as it will provide your doctor with important information to better understand your history and your present needs.*

## Part I: Your Health Concerns or Symptoms and How They May Affect Your Life

1. Please describe your current health concern(s). Is it related to a work injury or car accident?

   _____

   _____

2. When did this situation or concern begin? _____

3. Have you done anything about this situation or concern or gotten any advice or treatment for it? ___Yes ___No
   - If yes, please describe below:

| Modality | Past | Currently | Helpful? |
|---|---|---|---|
| **Chiropractic** | | | |
| **M.D.** | | | |
| **Acupuncture** | | | |
| **Physical Therapy / Occupational Therapy** | | | |
| **Yoga / Pilates / Tai Chi / Chi Gong** | | | |
| **Essential Oils** | | | |
| **Homeopathy** | | | |
| **Massage Therapy** | | | |

4. Please grade the level to which this health concern affects these aspects of your functioning/quality of life.

**0 - It does not seem to affect me.** **1 - It seems to slightly affect me.**
**2 - It seems to moderately affect me.** **3 - It seems to drastically affect me.**

| | | | | | |
|---|---|---|---|---|---|
| Affect on work | 0 1 2 3 | Affect on recreation/play | 0 1 2 3 | Affect on rest/sleep | 0 1 2 3 |
| Affect on social life | 0 1 2 3 | Affect on walking | 0 1 2 3 | Affect on sitting | 0 1 2 3 |
| Affect on exercise | 0 1 2 3 | Affect on eating | 0 1 2 3 | Affect on love life | 0 1 2 3 |

Concern about particular symptom/condition 0 1 2 3 Concern about Health 0 1 2 3

Comments _____

5. Have any other family members had the same or similar concerns? ___ Yes ___ No
   - If yes, what did he/she do about them?_____
   - Did it seem to work? _____
6. Is there any time when you don't feel this condition or it is not on your mind? __Yes __No
   - If yes, when? _____
7. Is there any time of day or activity that makes you more aware of it? __Yes __No
   - If yes, when? _____
8. Why do you think this has happened or continues to happen? _____

   _____
   - Do you think this is the sole cause? __Yes __No
   - If no, what else is involved? _____
9. If this condition or symptom were to go away tomorrow, what would be different about your life?

   _____

## Part II – Stress Survey: Please grade the following stresses in order of increasing intensity:

**0 - no awareness of any stress** **1 - slightly stressful**
**2 - moderately stressful** **3 - extremely stressful**

1. **Overall Physical Stress, Trauma:** Includes: difficult birth, falls, accidents, injuries, postural stress, physical abuse, repetitive work stressors (typing, bending, reaching)
   0 1 2 3

2. **Overall Emotional/Mental Stress:** Includes: loss of loved ones, rapid change in life situation, mental, emotional or sexual abuse, relationship concerns, job concerns, legal concerns, financial concerns, move of home/school, separation/divorce, stress of being ill or caretaker for someone who is ill
   0 1 2 3

3. **Overall Chemical Stress:** Includes: drugs, medications, fumes, processed foods, fast food, second-hand smoke, energy drinks, sodas, environmental toxins
   0 1 2 3

   Comments: _____

4. Do you belong to a Health Club or have a home exercise routine? ____Yes ____No
   - If yes, please describe: _____
5. Do you drink filtered water? ____Yes ____No
6. In general, what types of foods do you eat? _____
   _____
   - Do you have a vegetarian, vegan, or paleo diet? ____Yes ____No _____
7. Do you have a meditation, prayer, or other spiritual practice? ____Yes ____No
   Comments: _____
   _____
8. When stressed, how do you "center yourself' or "re-group"?
   _____
9. What aspects of your life please you, bring you joy, or help you to feel better about yourself?
   _____
10. Are there any particular factors or elements about your life that you feel give you an edge, or add to your health?
    _____
11. Are there any particular factors or elements about your life that you feel impair your opportunity for your best health?
    _____

## Part III – Health and Healing History:

1. Review of Systems:

**ALLERGY/IMMUNOLOGY**

| | | |
|---|---|---|
| Autoimmune Disease | Y | N |
| Drug Allergies | Y | N |
| Food Allergies | Y | N |
| Seasonal Allergies | Y | N |

Other _____

**CARDIOVASCULAR**

| | | |
|---|---|---|
| Chest Pain | Y | N |
| High Blood Pressure | Y | N |
| Leg Cramping | Y | N |
| Palpitations | Y | N |
| Swelling of feet, ankles, hands | Y | N |

Other _____

**EAR/NOSE/THROAT/MOUTH**

| | | |
|---|---|---|
| Ear Infection | Y | N |
| Hearing Loss | Y | N |
| Ringing in ears/tinnitus | Y | N |
| Sinus Problems | Y | N |
| Snoring | Y | N |
| Sore Throat | Y | N |
| Thrush | Y | N |

Other _____

**ENDOCRINE**

| | | |
|---|---|---|
| Diabetes | Y | N |
| Excessive Thirst | Y | N |
| Fatigue | Y | N |
| Glandular or hormone problem | Y | N |
| Thyroid problems | Y | N |
| Too hot/cold | Y | N |

Other _____

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**EYES**

| | | |
|---|---|---|
| Blurred vision/double vision | Y | N |
| Migraine auras | Y | N |
| Wear glasses/contact lenses | Y | N |

Other _____

**GASTROINTESTINAL**

| | | |
|---|---|---|
| Abdominal pain | Y | N |
| Constipation | Y | N |
| Diarrhea | Y | N |
| Heartburn/GERD | Y | N |
| Loss of appetite | Y | N |
| Nausea/vomiting | Y | N |
| Stomach pain | Y | N |
| Ulcer | Y | N |

Other _____

**HEMATOLOGIC/LYMPHATIC**

| | | |
|---|---|---|
| Anemic | Y | N |
| Lymphedema | Y | N |
| Swollen glands | Y | N |

Other _____

**MIND/STRESS**

| | | |
|---|---|---|
| Anxiety | Y | N |
| Depression | Y | N |
| Memory loss or confusion | Y | N |
| Sleep problems | Y | N |

Other _____

**MUSCULOSKELETAL**

| | | |
|---|---|---|
| Arthritis | Y | N |
| Broken bones | Y | N |
| Fibromyalgia | Y | N |
| Joint stiffness or swelling | Y | N |
| Weakness of muscles/joints | Y | N |

Other _____

**NEUROLOGICAL**

| | | |
|---|---|---|
| Convulsions or seizures | Y | N |
| Dizzy/lightheaded | Y | N |
| Frequent or recurrent headaches | Y | N |
| Vertigo | Y | N |

Other _____

**RESPIRATORY**

| | | |
|---|---|---|
| Asthma or wheezing | Y | N |
| Frequent cough | Y | N |
| Short of breath | Y | N |
| Sinus issues | Y | N |

Other _____

**SKIN**

| | | |
|---|---|---|
| Change in appearance of mole | Y | N |
| Change in hair or nails | Y | N |
| Skin rash or itching | Y | N |

Other _____

**URINARY**

| | | |
|---|---|---|
| Incontinence | Y | N |
| Kidney stones | Y | N |
| Painful urination | Y | N |
| Urinate often | Y | N |

Other _____

**WOMEN ONLY:**

| | | |
|---|---|---|
| Breast Feeding | Y | N |
| Breast Pain | Y | N |
| Breast Lump | Y | N |
| Fertility Issues | Y | N |
| Irregular Periods | Y | N |
| Painful Periods | Y | N |
| Pregnant | Y | N |

- EDD: _____

Other _____

2. Please tell me about any current or past injuries or accidents:
   - Car: _____
   - Sports: _____
   - Horse/other animals: _____
   - Broken bones/significant sprains: _____

   - Infections? _____
   - Other: _____

3. Please list medications (prescription or non-prescription) you have taken within the **past 60 days**:

| *What did you take?* | *Reason:* |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

4. Please list medications (prescription or non-prescription) you have taken in the past for **more than 3 months**:

| *What did you take?* | *Reason:* |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

5. Please list any herbs, nutritional supplements or natural remedies you take regularly.
   _____
   _____

6. Please list anything else you would like for me to know about you.
   _____
   _____

## Part IV: Your Care in Our Office

*Please use this scale for the following question:*

***a) very important to me*** ***b )important to me***
***c) not so important to me*** ***d) does not apply***

How do you hope to benefit from care in our office?

____ Improvement of my physical symptoms
____ Improvement of my emotional/mental symptoms
____ Improvement of my ability to react or respond to stress
____ Improvement in enjoyment of life
____ Overall improved quality of life

***Thank you for choosing our office.***
***We look forward to helping you to be successful on your journey towards greater health and wellness.***