New Patient Health Questionnaire

Be Well Total Health | 11260 Wilbur Avenue, Suite 304, Porter Ranch, CA 91326
T: 818.456.2028 | W: www.bewelltotalhealth.com

Patient Information		Date:
Last Name	First Name	Middle Initial

Health Concerns

What is your **primary** health concern?

What services interest you? (mark all that apply)

☐ Injury Prevention	☐ Acupuncture and Oriental Medicine	☐ Emotional Balancing	☐ Allergies
☐ Posture and Spinal Alignment	☐ Balance and Coordination Training	☐ Chiropractic for Kids	☐ Weight Loss
☐ Patient Education Classes	☐ Strengthening/Corrective Exercises	☐ Hormone Balancing	☐ Anti-Aging
☐ Body Composition Counseling	☐ Nutritional and Supplement Counseling	☐ Treatment for Pain	☐ Brain Health
☐ Massage Therapy	☐ Ayurveda and Lifestyle Counseling	☐ Energy therapy	Other:_____

Were you were injured while at work, in a motor vehicle collision, or any another accident/trauma? ☐ Yes ☐ No

How long have you been experiencing your **primary** complaint? When did it start?

How would you describe your **primary** complaint?

☐ Sharp ☐ Dull ☐ Shooting ☐ Numbness ☐ Tingling ☐ Throbbing ☐ Cramping ☐ Stiffness ☐ Swelling
☐ Burning ☐ Achy ☐ Other_____

How often do you experience the **primary** complaint? ☐ Constant ☐ Comes & Goes

Activities that make you feel worse:

Sitting	☐ Better ☐ Worse	Walking	☐ Better ☐ Worse	Lying Down	☐ Better ☐ Worse
Standing	☐ Better ☐ Worse	Bending	☐ Better ☐ Worse	Twisting	☐ Better ☐ Worse

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

☐ 1 No pain or discomfort	☐ 2 Slight discomfort	☐ 3 Pain that does not affect my activity	☐ 4 Pain that affects my daily activities	☐ 5 Pain that prevents performing my daily activities	☐ 6 Pain that limits my work schedule	☐ 7 Pain that prevents working at all	☐ 8 Pain that prevents working and all personal activity	☐ 9 Pain that keeps me bed ridden	☐ 10 Pain that causes thoughts of suicide

What do you believe is causing your **primary** complaint?_____

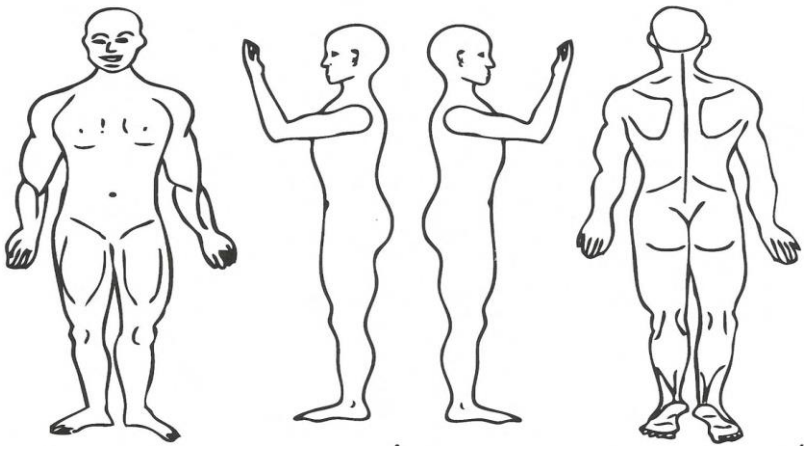
Is your condition getting worse? Please explain_____

Does the condition interfere with:

Work life	☐ Yes ☐ No	Explain:	_____
Daily Life	☐ Yes ☐ No	Explain:	_____
Sleep	☐ Yes ☐ No	Explain:	_____

Has there been a medical diagnosis? ☐ Yes ☐ No What is the diagnosis? _____

Please mark all areas of concern on the diagrams below, and feel free to include any additional details.



New Patient Health Questionnaire

Patient Name_____

Have you had:				
X-rays	☐ Yes	☐ No	Date performed and area: _____	Reason:_____
CT Scan	☐ Yes	☐ No	Date performed and area: _____	Reason:_____
MRI Imaging	☐ Yes	☐ No	Date performed and area: _____	Reason:_____
Ultrasound	☐ Yes	☐ No	Date performed and area: _____	Reason:_____

List any other concerns you would like our help with:	
1)	4)
2)	5)
3)	6)

Have you experienced Chiropractic care before? ☐ Yes ☐ No When?

Do you feel healthy? Please explain:

What relieves the condition? Please list all therapies/activities that are helping:

Health History	Currently	Previously		Currently	Previously		Currently	Previously
Aids/HIV	☐	☐	Goiter	☐	☐	Pinched Nerve	☐	☐
Alcoholism	☐	☐	Gout	☐	☐	Pleurisy	☐	☐
Allergy Shots	☐	☐	Muscular Dystrophy	☐	☐	Pneumonia	☐	☐
Anemia	☐	☐	Heart Disease	☐	☐	Prostate Problems	☐	☐
Anorexia	☐	☐	Headache (Tension)	☐	☐	Psychiatric Care	☐	☐
Appendicitis	☐	☐	Hernia	☐	☐	Rheumatoid Arthritis	☐	☐
Arthritis	☐	☐	Herniated Disk	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Herpes	☐	☐	Scarlett Fever	☐	☐
Bleeding Disorders	☐	☐	High Cholesterol	☐	☐	Stroke	☐	☐
Breast Lumps	☐	☐	Influenza	☐	☐	Suicide Attempt	☐	☐
Bronchitis	☐	☐	Kidney Disease	☐	☐	Thyroid Problems	☐	☐
Bulimia	☐	☐	Liver Disease/ Hepatitis	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Measles	☐	☐	Tuberculosis	☐	☐
Cataracts	☐	☐	Mental Disorder/ Depression	☐	☐	Tumor Growth	☐	☐
Chicken Pox	☐	☐	Migraine Headaches	☐	☐	Typhoid Fever	☐	☐
Fatigue/Chronic pain	☐	☐	Miscarriage	☐	☐	Ulcers	☐	☐
Diabetes	☐	☐	Mononucleosis	☐	☐	Vaginal Disease	☐	☐
Emphysema/COPD	☐	☐	Multiple Sclerosis	☐	☐	Sexually Transmitted Disease	☐	☐
Epilepsy	☐	☐	Mumps	☐	☐	Whooping Cough	☐	☐
Fractures	☐	☐	Osteoporosis	☐	☐	Glaucoma	☐	☐
Parkinson's Disease	☐	☐	Stress	☐	☐	Recreational Drug Use	☐	☐

New Patient Health Questionnaire

Patient Name_____

Injuries		
List any auto collisions, job injuries, sports injuries, or any other traumas caused by falls or impacts. Begin with the most recent:		
Type of Injury	**Type of Treatment**	**Date of Injury**
1)		
2)		
3)		
4)		

Hospitalizations/Surgeries/Medications/		
Do you have a pacemaker? ☐Yes ☐No		
Do you have any metal or plastic inside your body *(such as pins, wires/artificial joints, clamps, plates, etc.)*? ☐ Yes ☐ No		
Please list all the surgeries and/or hospitalizations you have had (including cosmetic):		
Type of Surgery	**Reason**	**Date**
1)		
2)		
3)		
4)		
5)		

List any prescription or over-the-counter medication you are currently taking *(include birth control, aspirin, pain medication)*

Medication	**Reason**	**Medication**	**Reason**
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Please list any vitamins, herbs and nutritional supplements you are currently taking and for what reason:

Have you ever had a lapse of memory?	☐Yes ☐No Explain:
Have you ever been knocked unconscious?	☐Yes ☐No Explain:
Have you ever had a spinal tap or spinal injection/epidural?	☐Yes ☐No Explain:

List any broken bones or dislocations that you have had:

Have you ever had full body anesthesia? (i.e., to remove tonsils, wisdom teeth, etc.) ☐Yes ☐No	
Have you ever been vaccinated?	☐Yes ☐No
Do you get regular flu shots?	☐Yes ☐No When was your last flu shot? Date: _____ / _____ / _____

Family History: Please check if any of your family members have or ever had any of the following conditions:

- ☐ Cancer Relation:_____
- ☐ Stroke Relation:_____
- ☐ Diabetes Relation:_____
- ☐ Heart Disease Relation:_____
- ☐ High Blood Pressure Relation:_____
- ☐ High Cholesterol Relation:_____

New Patient Health Questionnaire

Patient Name_____

Systems Review			
Mark the following conditions that are **currently** a cause of significant concern for you.			
General			
☐ Consistent Fainting	☐ Convulsions	☐ Wheezing	☐ Chills
☐ Loss of Weight	☐ Night Sweats	☐ Dizziness	☐ Fatigue
☐ Weight Gain	☐ Depression	☐ Loss of Sleep	☐ Fever
☐ Neuralgia	☐ Headache	☐ Nervousness	☐ Loss of Appetite
Gastro-Intestinal			
☐ Constipation	☐ Vomiting	☐ Vomiting Blood	☐ Nausea
☐ Liver Problems	☐ Gall Bladder Problems	☐ Hemorrhoids	☐ Diarrhea
☐ Rectal Bleeding	☐ Stomach Pain	☐ Poor Appetite	☐ Jaundice
☐ Poor Digestion	☐ Others such as: Crohn's, IBS, Ulcerative Colitis, Diverticulitis_____		

Eye/Ear/Nose/Throat			
☐ Nasal Obstruction	☐ Enlarged Thyroid	☐ Pain in the Eyes	☐ Asthma
☐ Sore Throat	☐ Nose Bleeds	☐ Hay Fever	☐ Ear Noise/Ringing
☐ Crossed Eyes	☐ Tonsillitis	☐ Poor Vision	☐ Earache
☐ Frequent Colds	☐ Sinusitis	☐ Ear Discharge	☐ Deafness/Hearing loss
☐ Hoarseness	☐ Lymph nodes	☐ Blurry/Double vision	☐ Difficulty swallowing
Respiratory			
☐ Chest Pain	☐ Chronic Cough	☐ Difficulty Breathing	☐ Allergies
☐ Spitting Blood	☐ Spitting Phlegm	☐ Smoking:#___packs/day	
Muscles/Joints/Bones			
☐ Spasms/Cramps	☐ Neck pain	☐ Hip/Knee/Ankle Pain	☐ Foot pain
☐ Spinal Curvature/ Scoliosis	☐ Mid back pain	☐ Shoulder/Elbow/Wrist Pain	☐ Swollen joints
☐ Muscle Weakness	☐ Low back pain	☐ Jaw/TMJ Pain	☐ Twitching/Tremors
Cardio-Vascular			
☐ Ankle Swelling	☐ High Blood Pressure	☐ Low Blood Pressure	☐ Varicose veins
☐ Heart Trouble/Disease	☐ Pain Over Heart	☐ Poor Circulation	☐ Blood clots
☐ Rapid Heart/Palpitations	☐ Slow Heart	☐ Stroke	☐ Shortness of Breath
Skin			
☐ Bruise Easily	☐ Dryness	☐ Eczema	☐ Warts/Moles
☐ Hives/Rashes	☐ Itching	☐ Sensitive Skin	☐ Allergies
Genitourinary			
☐ Urinary tract infection	☐ Kidney stone	☐ Kidney/Bladder infection	☐ Yeast Infection

New Patient Health Questionnaire

Patient Name_____

Menstrual Cycle (women)							
☐	Cramping/Bloating	☐	Excessive Flow/Heavy	☐	Bright Red Color	☐	Hot Flashes
☐	Irregular Cycle	☐	Light flow	☐	Brownish Color	☐	Mood Swings
☐	Cravings	☐	Back Pain	☐	Dark, Clotted Blood	☐	Headaches
☐	Other Complaints?						

WOMEN ONLY:

Are you pregnant?	☐ Yes	☐ No	How many wks/mths? _____ When are you due?_____
Are you breast feeding?	☐ Yes	☐ No	
Do you have monthly periods?	☐ Yes	☐ No	Date of last period: ____ / ____ / ____
Are you going through menopause?	☐ Yes	☐ No	Are your periods regular? ☐ Yes ☐ No

Lifestyle/ Habits	
Sleep	How is your sleep? ☐ Restful ☐ Restless ☐ Wake up during the night ☐ Hard to fall asleep ☐ Bad dreams/Nightmares ☐ Don't feel rested upon waking ☐ Wake up too early and can't fall back asleep ☐ Other:_____ What time do you usually go to sleep?_____ Number of hours of sleep per night? _____
Exercise	How often do you exercise? ☐ Daily ☐ 3x Week ☐ 2x Week ☐ 1x Week ☐ I don't exercise Please describe your exercise activities:
Digestion	How is your Digestion? ☐ Adequate ☐ Poor ☐ Acid Reflux ☐ Burp Often ☐ Bloating ☐ Burning Pain Other complaints?
Bowels	How often do you have bowel eliminations? ☐ 3x daily ☐ 2x daily ☐ 1x day ☐ Skip days ☐ Constipated *Amount?* ☐ Seems normal to me ☐ Doesn't feel complete *Consistency?* ☐ Normal ☐ Hard or Dry ☐ Very Soft ☐ Diarrhea *Color?* ☐ Brown ☐ Black ☐ Whitish Other: ☐ Lots of mucous ☐ Lots of Gas/Cramping ☐ Foul Smell Other complaints:_____
Urination	How frequent is your daily urination? ☐ Every 2-3 hours ☐ Too frequent ☐ Sense of urgency ☐ Too small amt ☐ Too large amt ☐ Burning ☐ Dribbling ☐ Up at night several times ☐ Don't completely empty bladder
Therapies Used	☐ Chiropractic ☐ Massage therapy ☐ Naturopathy ☐ Homeopathy ☐ Aromatherapy/Essential Oils ☐ Chinese/Oriental Medicine ☐ Acupuncture ☐ Ayurveda ☐ Yoga therapy ☐ Osteopathy ☐ Physiotherapy ☐ Energy healing ☐ Reflexology

New Patient Health Questionnaire

Patient Name_____

Advanced Questions Regarding Toxicity Exposure

Electromagnetic Exposure: ***How many hours do you spend daily?***					
Watching TV		Working on a computer		Talking on a landline phone	
Using a tablet		Wearing a headset		Talking on a cellular phone	
Near electrical equipment for long periods of time (such as copy machines, high power lines, computers)?					
When you sleep, is your head within 10 feet of a plug in clock (such as on a night stand)? Yes/No					
Clothing	How often do you wear 100% natural clothing (cotton, ramie, wool, silk, or linen)?				
	Synthetic clothing (polyester, acrylic, nylon, rayon, etc.)?				
	Blends (natural fabric combined with synthetic)? Underwire bra?				
Sunlight	Amount of natural sunlight you receive daily outside? _____ Through windows? _____				
	Hours spent daily under fluorescent lights?				
	Do you use Chromalux light bulbs at home? _____ At work? _____				
Eyewear	Do you wear contact lenses? _____ Glasses? _____ If so, how many hours a day? _____				
	Do your lenses have tints? _____ An anti-glare coating? _____ A scratch resistant coating? _____				
Personal Care Products					
Appliances					
Cookware					
Shower Filter					
Pets					
Bedroom/Sleep					
Electrical Devices					
Toxic Body Exposure					
Other	Do you have any body piercings? ☐ Yes ☐ No Tattoos? ☐ Yes ☐ No				

Dental Work: (Indicate how many of the following you have)

Silver Fillings	_____	Composites (tooth-colored)	_____	Posts	_____	Braces	_____
Extractions	_____	Gold crowns or inlays	_____	Temporaries	_____	Bleeding Gums	_____
Bridgework	_____	Stainless steel crows or inlays	_____	Partial or full dentures	_____	Sensitive Teeth	_____
Veneers	_____	Porcelain crowns or inlays	_____	Root canals	_____	Bad bite	_____
Implants	_____	Degussa Porcelain crowns or inlays	_____	Root canals with EndoCal	_____	New cavities	_____