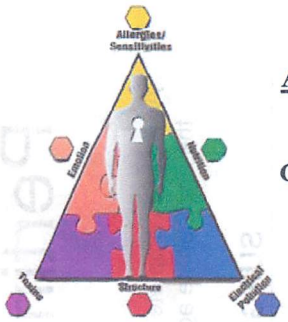

All American Wellness Center

Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: | Address:

City: | State/Prov: Zip/Postal Code:

Home Phone: | Birth Date: Age: Sex: ☐ M ☐ F

Cell Phone: | E-mail:

Social Security #: | Driver's License Number:

Social Insurance #: | Circle One: Married Single Widowed Divorced Separated

Business Employer: | Type of Work:

Business Phone: | Spouse's Social Security #:

Name of Spouse: | Spouse's Social Insurance #:

Spouse's Employer: | Business Phone:

Type of Work: | Names and Ages of Children:

Referred to this office By:

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

MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ **DATE:** _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching, or passing gas
___ Heartburn
___ Intestinal/Stomach pain

Total _____

EARS

___ Itchy ears Total
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Total 0

EMOTIONS

___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability, or aggressiveness
___ Depression

Total _____

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

Total _____

EYES

___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near-or far-sightedness)

Total _____

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total _____

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

Total _____

JOINTS/MUSCLES

___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness

Total _____

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing

Total _____

MIND

___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

Total _____

MOUTH/THROAT

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

Total _____

NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

Total _____

SKIN

___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

Total _____

WEIGHT

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

Total _____

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

Total _____

GRAND TOTAL _____

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group scores and give a grand total.

- Optimal is less than 10
- Mild Toxicity: 10-50
- Moderate Toxicity: 50-100
- Severe Toxicity: over 100