HAVEN CHIROPRACTIC
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Schuylkill Haven, PA 17972

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570-385-7246 (PAIN) (Fax & 2nd Phone Line)

GENERAL INFORMATION

Name _____ Preferred Name_____ Date _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Age _____ Date of Birth _____ Place of Birth_____Gender: female _____ male_____

Married ____ Separated ____Divorced____Widowed ____Single____ Partnership ____ Do you have any children? Yes____No_____

If so, how many? _____ Age(s)_____ Gender(s)_____ Name(s)_____

Occupation _____ Nature of Business_____

How did you hear about our clinic? Website _____ Media_____ Friend/ family member_____

Has any other family member already been a patient at the clinic? _____

Who is your primary medical physician?_____

Have you ever lived or travelled outside the United States? Yes ____ No ____ If yes, when and where? _____

_____

Have you or your family recently experienced any major life changes? Yes____ No____ If yes, please comment:_____

_____

Have you experienced any major losses in life? Yes____ No____ If yes, please comment:_____

_____

Do you have any allergies? Yes____ No____ If yes, what are you allergic to and what is your reaction?_____

_____

Functional Diagnosis Questionnaire

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present. (Use the back of the page if necessary.)

PROBLEM	ONSET	FREQUENCY	SEVERITY

What diagnosis or explanation have been given to you?_____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please list all physicians you have seen for the above health conditions:

1._____ 4._____

2._____ 5._____

3._____ 6._____

PAST MEDICAL & SURGICAL HISTORY

ILLNESSES	Date	Date	Date	Comments
Chicken Pox		X	X	
German Measles		X	X	
Measles		X	X	
Mumps		X	X	
Whooping cough		X	X	
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue				
Crohn's Disease/ Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				
High blood pressure				
Irritable bowel				
Kidney stones				
Mononucleosis				
Pneumonia				
Rheumatic fever				
Sinusitis				
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				

DIAGNOSTIC STUDIES	Date	Date	Date	Comments
Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy/Colonoscopy				
Upper GI Series				
Barium Enema				
CAT scan/MRI/X-rays				
Bone scan				
Bone Density Test				
Carotid Artery Ultrasound				
Other (describe)				
OPERATIONS	**Date**	**Date**	**Date**	**Comments**
Tonsillectomy		X	X	
Tubes in Ears				
Appendectomy		X	X	
Gall Bladder		X	X	
Hernia				
Hysterectomy		X	X	
Other (describe)				

MEDICATIONS & SUPPLEMENTS

MEDICATION LOG

Please indicate the type of medications you are taking now. Please include non-prescription drugs.

Medication Name	Date started	Dated Stopped	Dosage	# per day

SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name and Brand	Dose	Frequency	Dated Started	Reason for use

HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

CHILDHOOD HEALTH HISTORY

As a child, were there any foods that you had to avoid because they gave you symptoms? Yes____ No_____

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

FEMALE MEDICAL HISTORY (for women only)

OBSTETRICS HISTORY *Check box if yes and provide number of*

❑ Pregnancies _____ ❑ Caesarean _____ ❑ Vaginal deliveries _____

❑ Miscarriage _____ ❑ Abortion _____ ❑ Living Children _____

❑ Post partum depression ❑ Toxemia ❑ Gestational diabetes

❑ Baby over 8 pounds ❑ Breast feeding? Yes_____ No_____ For how long?_____

GYNECOLOGICAL HISTORY

Age at 1st period:_____ Menses Frequency: _____ Length: _____ Pain: Yes____ No ____ Clotting: Yes ____ No ____

Has your period skipped? _____ For how long? _____ Do you currently use contraception? Yes ____ No ____ If yes, what type?

❑ Condom ❑ Diaphragm ❑ IUD ❑ Partner vasectomy

❑ Patch ❑ Birth control pills If yes, does it agree with you? Yes ___ No ___ ❑ Nuva Ring How long?_____

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes____ No_____

Last Mammogram/Thermogram _____ Breast Biopsy/Date _____ Last PAP Test: _____ Normal _____ Abnormal _____

Date of last Bone Density: _____ Results: ❑ High ❑ Low ❑ Within normal range

Are you in menopause? Yes _____ No _____ Age at Menopause _____

Do you take: ❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone

❑ Provera Other _____ How long have you been on hormone replacement? _____

Have your medications or supplements ever caused you unusual side effects or problems? Yes ____ No ____ If yes, please describe:

_____

FAMILY MEDICAL HISTORY

(Please mark any health problem(s) your family has suffered with either now or in the past)

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Heart Attack												
Stroke												
Cancer (Specify Type)												
ADD/ADHD												
ALS												
Alzheimer's												
Anemia												
Anxiety												
Arthritis (Specify Type)												
Asthma												
Autism												
Autoimmune Diseases												
Bladder disease												
Blood clotting problems												
Celiac disease												
Dementia												
Depression												
Diabetes (Specify I or II)												
Eczema												
Emphysema												
Epilepsy												
Genetic disorders												
Glaucoma												
High Blood Pressure												
Bowel Disease												
Insomnia												
Kidney disease												
Multiple Sclerosis												
Obesity												
Osteoporosis												
Parkinson's												
Pneumonia/Bronchitis												
Psoriasis												
Psychiatric disorders												
Sleep Apnea												
Smoking addiction												
Ulcers												

Any other family history we should know about? Yes _____ No _____If yes, please comment: _____

NUTRITION & LIFESTYLE HISTORY

Have you made any changes in your eating habits because of your health? Yes____ No_____

Do you currently follow a special diet or nutritional program? Yes____ No_____

Check all that apply:

- ❑ Low Fat
- ❑ Low Starch/Carbohydrate
- ❑ Mixed Food Diet(Animal and Vegetable Sources)
- ❑ The Blood Type Diet
- ❑ High Protein
- ❑ Metabolic Typing Diet
- ❑ Vegetarian
- ❑ Specific Program for Weight Loss/Maintenance Type:_____
- ❑ Total Calorie Restriction
- ❑ Vegan
- ❑ Diabetic
- ❑ Gluten Free
- ❑ No Dairy
- ❑ Low Sodium
- ❑ No Wheat

Height (feet/inches)_____ Current Weight_____

Usual weight range +/- 5 lbs_____ Desired Weight range +/- 5 lbs_____

Highest adult weight _____ Lowest adult weight _____

Are there any foods that you avoid because they give you symptoms? Yes____ No_____

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.?Yes _____ No _____ If yes, please explain:_____

EXERCISE

Current Exercise program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency per week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength Training			
Other (Pilates, yoga, etc.)			
Sports or Leisure Activities			

List problems that limit activity: _____

Do you feel fatigued after exercise? Yes _____ No _____ Do you usually sweat when exercising? Yes _____ No_____

SOCIAL HISTORY

SLEEP/REST

Average number of hours you sleep ❑ >10 ❑ 8 – 10 ❑ 6 – 8 ❑ <6

Do you have trouble staying asleep? Yes ____ No _____

Do you have trouble falling asleep? Yes ____ No _____

Do you feel rested upon awakening? Yes ____ No _____

Do you snore? Yes ____ No _____

TOBACCO HISTORY

Currently using tobacco? Yes _____ No _____ How Long ? _____ What type? Cigarette _____ Packs per day: _____

Smokeless _____ Cigar _____ Pipe _____ Patch/Gum _____ **Previous** smoking: How many years? _____ Packs per day: _____

ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits

None _____ 1-3 _____ 4-6 _____ 7-10 _____ >10 _____ If none skip to "Other Substances"

Previous alcohol intake? Yes ____ (Mild _____ Moderate _____ High _____)

ESTABLISHING HEALTH GOALS

Personal Message

Before we begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

I've discovered that any discussion of the correct way to achieve health and stay healthy is, in actuality; a discussion of how you have lived your life up to this point and how you will live it in the future.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

What do you hope to achieve in your visit with us? _____

If you had a magic wand and could erase three problems, what would they be?

1. _____

2. _____

3. _____

Have you made the decision to change? To do what it takes to get well? Yes_____ No_____

I have read something interesting: ***"The definition of insanity is to keep doing the same thing and expecting different results".*** If you keep following the same course of treatment you have been following will your results really change? Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination.

Most people I ask tell me they've made the decision to change. But how many people have truly decided to change? Very few! Why?

Because there is a big difference between deciding something and having “reasons” to actually do it.

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:

List up to 5 things that you have ***been unable* to do as a result of your present symptoms. Please be specific.**

_____

_____

_____

List up to 5 things that you plan to do once you are feeling better. Please be specific. (Use extra pages if necessary)

_____

_____

_____

Are there any other health goals you want to achieve?

_____

_____

_____

READINESS ASSESMENT

Rate on a scale of: 5 (very willing) to 1(not willing)

In order to improve your health, how willing are you to:

Significantly modify your diet: 5_____ 4_____ 3_____ 2_____ 1_____

Take several nutritional supplements each day: 5_____ 4_____ 3_____ 2_____ 1_____

Modify your lifestyle: 5_____ 4_____ 3_____ 2_____ 1_____

Practice relaxation techniques: 5_____ 4_____ 3_____ 2_____ 1_____

Engage in regular exercise: 5_____ 4_____ 3_____ 2_____ 1_____

Have periodic lab tests to assess progress: 5_____ 4_____ 3_____ 2_____ 1_____

Comments:_____

Thank you for taking the time to complete this health history medical questionnaire.

The information derived from all of these medical forms will provide invaluable data.

Each section builds upon the other, allowing me and other physicians the opportunity to discover the **“missing key”** that will solve your health problem.

Once all the sections of this form and the questionnaires have been filled out please return them to our office and we’ll make an appointment for our initial consultation.

I thank you once again and look forward to helping you achieve a **“return to health and well being.”**

Sincerely,

Dr. Borger