Well Within
CHIROPRACTIC & WELLNESS

Health History

Patient name:_____ Date: _____

Address/Zipcode:_____

Date of Birth: _____ Do you have Medicare Part B: ☐Yes ☐No

Sex:☐Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ Employer: _____

Email:_____ Spouses Name: _____

Who may we thank for referring you? _____

Phone number: Cell _____ _____ Home _____

Emergency Contact: _____ Phone # _____

Appointment reminders? ☐ Yes ☐ No If yes: ☐ E-mail (24hr before) ☐ Text Msg (2hrs before)

Reason for visit: _____

Is this due to an accident? _____☐Auto ☐ Work related ☐ Home

If so, has it been reported to: ☐ Insurance company ☐ Employer ☐ Work Comp?

When did the symptoms appear? _____

Is the condition getting worse? _____

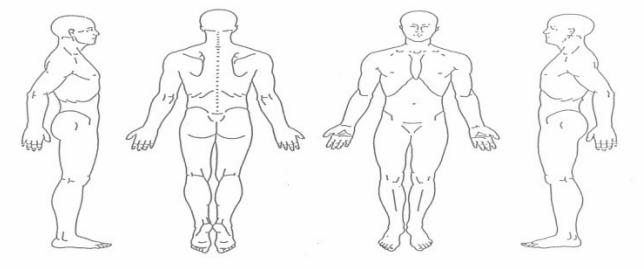
How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Recreation ☐ Daily routine ☐ _____

Are the following painful or difficult? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Bending

☐ Lifting ☐ Other _____



Where do you feel the pain:

Rate your pain 1-10 _____

Do you feel the following:

☐ Numbness ☐ Tingling ☐ Weakness

☐ Sharp ☐ Dull ☐ Ache ☐ Throbbing

☐ Burning ☐ Swelling ☐ Stiffness ☐ Cramps

How does your condition make you feel? _____

What would you be able to do/enjoy that you can't currently if this condition was gone?

_____

Have you been treated for this condition previously? ☐ Yes ☐ No

☐ Medication ☐ Surgery ☐ Chiropractic ☐ Nutrition ☐ Acupuncture ☐ _____

Date of last exam: Physical _____ Blood work _____ Urine _____

X-Rays_____ MRI/CT/Ultrasound _____

Have you had or have any on the following:

AIDS	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No	Allergy shots	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Anorexia	☐ Yes ☐ No	Appendicitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Autoimmune	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	Blood pressure	☐ Yes ☐ No	Breast lump	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Bulimia	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Chemical	☐ Yes ☐ No	Chicken pox	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Dependency		Emphysema	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Goiter	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Hernia	☐ Yes ☐ No	Herniated Disc	☐ Yes ☐ No	Herpes	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Measles	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Mumps	☐ Yes ☐ No
Mononucleosis	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No	Pinched nerve	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Prostate problem	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Prosthesis	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Rheumatoid	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Arthritis		Suicide attempt	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Typhoid fever	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	Vaginal	☐ Yes ☐ No
Venereal disease	☐ Yes ☐ No	Whooping cough	☐ Yes ☐ No	infections	

Other: _____

Do you get headaches? ☐ Yes ☐ No How often _____ How would you describe them?:

☐ Migraine ☐ Visual disturbance ☐ Nausea ☐ Tension ☐ Vomiting ☐ Related to allergies

☐ Aura ☐ Light sensitive ☐ Related to allergies ☐ Ocular migraine

Are you pregnant? ☐ Yes ☐ No If so, due date?_____

Have you ever taken antibiotics? ☐ Yes ☐ No When_____

Are you on birth control? ☐ Yes ☐ No Have you used hormone replacement therapy ☐ Yes ☐ No

Are you Vegetarian ☐ Yes ☐ No Do you skip meals ☐ Yes ☐ No

How much sugar do you eat? ☐ Little ☐ Moderate ☐ High Do you crave sugar ☐ Yes ☐ No

Injuries/Surgeries you have had:	Description	Date
Falls		
Head injuries		
Broken Bones		
Auto Accidents		
Surgeries		

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3

Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome? **Yes** **No**

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3

Have you had your gallbladder removed? **Yes** **No**

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions: