Big Sky Wellness Center
265 Foys Canyon Rd.
Kalispell, MT 59901
406-755-4119 (office)
406-755-0577 (fax)

BIG SKY WELLNESS CENTER
More Health. More Life.

PATIENT HEALTH HISTORY

Date: _____

Name: _____

Physical Address: _____ Occupation: _____

City: _____State:_____ Zip: _____ Employer: _____

Mailing Address: _____

City: _____State:____ Zip: _____

Home Phone #: _____ E-Mail: _____

Cell Phone #: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: □Male □Female Weight: _____ Height: _____

Marital Status: □Married □Single □Divorced □Separated □Other_____

Name of Spouse or Nearest Relative: _____ Phone: _____

Referred by: _____ May we thank them for the referral? □Yes □No

Previous Chiropractic Care? □Yes □No

If yes, what spinal maintenance programs were you given to follow to maximize the future stability of your spine?

_____

Did you follow it? □Yes □No If not, why? _____

Please list below the top 3 main reasons for your appointment, in order of importance.

- **Please tell me about it in <u>as much detail as possible</u>.**
- **Please list the very <u>first time</u> that you noticed the condition.**

1.

2.

3.

If you were to guess, what do you think is the cause of your complaints?

What other healthcare providers have you seen regarding this problem(s)?

What diagnosis were you given?

Have you lost workdays? □Yes □No If yes, when and how many? _____

Family Physician: _____

Date of last physical examination: _____

Date of last blood work and results: _____

List any <u>accidents</u> or <u>falls</u> and <u>dates</u>:

□Auto: _____

□Recreation: _____

□Sports: _____

□Work Related: _____

□Other: _____

List any broken bones (fractures) or dislocations: _____

Have you ever used crutches? □Yes □No If yes, why? _____

Were you ever knocked unconscious? □Yes □No (If yes, please explain) _____

Have you ever had x-rays taken? □Yes □No When? _____ By Whom? _____

For what ailments were these x-rays made? _____

Do you wear orthotics or heel lifts? □Yes □No Fitted by whom? _____ When? _____

Do you suffer from any condition other than that for which you are now consulting us? □Yes □No _____

Operation and Procedures

□ I have <u>never</u> had any operations or surgeries

Date		Date		Date	
_____	Vaccinations	_____	Spinal Taps/Injections	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gallbladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach

Other hospitalizations: _____

Current medications (prescription or over-the-counter): For what purpose are you taking these medications?

If you are taking NO prescription or over the counter medications (Ibuprofen, Aleve, Prilosec, etc.) **Please check here:** □

_____ _____

_____ _____

_____ _____

_____ _____

Current Supplements For what purpose are you taking these supplements?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical History

□ Arthritis
□ Allergies/hay fever
□ Asthma
□ Alcoholism
□ Alzheimer's disease
□ Autoimmune disease
□ Blood pressure problems
□ Bronchitis
□ Cancer
□ Chronic fatigue syndrome
□ Carpal tunnel syndrome
□ Cholesterol, elevated
□ Circulatory problems
□ Colitis
□ Dental problems
□ Depression
□ Diabetes
□ Diverticular disease
□ Drug addiction
□ Eating disorder
□ Epilepsy
□ Emphysema
□ Eyes, ears, nose, throat problems
□ Environmental sensitivities
□ Fibromyalgia
□ Food intolerance
□ Genetic disorder
□ Glaucoma
□ Gout
□ Heart disease
□ Infection, Chronic
□ Irritable bowel syndrome
□ Kidney or bladder disease
□ Learning disabilities
□ Liver or gallbladder disease (stones)
□ Mental illness
□ Migraine headaches
□ Sinus problems
□ Stroke
□ Thyroid trouble
□ Obesity
□ Osteoporosis
□ Pneumonia
□ Sexually transmitted disease
□ Seasonal affective disorder
□ Skin problems
□ Tuberculosis
□ Ulcer
□ Urinary tract infection
□ Varicose veins
□ Other: _____

Additional Medical History-Women

Date of Last OB/Gyn Exam:_____
Mammogram: □Abnormal □Normal
PAP: □Abnormal □Normal
Number of children: _____
Date of last menstrual cycle:_____
Length of cycle _____ days
Interval of time between cycles _____ days
□ Surgical menopause
□ Menopause

Family Health History

(Biological Parents and Siblings)

□ Arthritis
□ Asthma
□ Alcoholism
□ Alzheimer's disease
□ Cancer
□ Depression
□ Diabetes
□ Drug addiction
□ Eating disorder
□ Genetic disorder
□ Glaucoma
□ Heart disease
□ Infertility
□ Learning disabilities
□ Mental illness
□ Migraine headaches
□ Obesity
□ Osteoporosis
□ Stroke
□ Suicide
□ Other: _____

Nutrition & Diet

□ Mixed food diet (animal and vegetable sources)
□ Vegetarian
□ Vegan
□ Salt restriction
□ Fat restriction
□ Starch/carbohydrate restriction
□ Total calorie restriction

Specific Food Restriction:

□ Dairy
□ Wheat
□ Eggs
□ Soy
□ Corn
□ All gluten
□ Other: _____

Eating Habits

□ Skip meals – which ones? _____
□ One meal a day
□ Two meals a day
□ Three meals a day
□ Graze (small frequent meals)
□ Generally eat on the run
□ Eat constantly whether hungry or not

Allergies / Sensitivities (Please specify)	**Typical Reaction:**
Foods:	
Drugs/Medications:	
Grasses, weeds, pollens:	
Dust, molds:	
Perfumes, cigarette smoke:	

Have you had previous allergy testing performed? Where?

List any foods that you crave or would have a difficult time living without: _____
(e.g. coffee, donuts, chocolate, cheese)

What is your blood type? (Circle one) A B AB O Don't Know

Rate your current stress level from 1-10 (1 being the lowest): _____

What have you tried to do to improve your state of health?

□ Diet modification □ Fasting □ Vitamins/minerals □ Herbs
□ Homeopathy □ Chiropractic □ Acupuncture □ Conventional Drugs
□ Other: _____

Is your general health currently getting better, worse, or staying the same. How do you know?

For our time together to be a true win for you, what do you want to take place over the course of your care here?

Energy - Vitality
□ Feel more vital
□ Have more energy
□ Have more endurance
□ Be less tired after lunch
□ Sleep better
□ Be free of pain
□ Get less colds and flu
□ Get rid of allergies
□ Not be dependent on over-the-counter medications, like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
□ Stop using laxatives and stool softeners

Body Composition
□ Lose weight
□ Burn more body fat
□ Be stronger
□ Have better muscle tone
□ Be more flexible
□ Other: _____

Stress, Mental, Emotional
□ Learn how to reduce stress
□ Think more clearly and be more focused
□ Improve memory
□ Be less depressed
□ Be less moody
□ Be less indecisive
□ Feel more motivated

Life Enrichment
□ Reduce my risk of degenerative disease
□ Slow down accelerated aging
□ Maintain a healthier life longer
□ Change from a "treating-illness" orientation to creating a wellness lifestyle

How long do you feel this will take?

Please list any self-destructive lifestyle habits: (e.g. smoking, lack of exercise, addictions, etc.)

What might it cost you if you don't significantly improve your lifestyle and any underlying contributors to compromised health? (For example: vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

What is your present level of commitment to change the underlying causes of problem(s), which relate to your lifestyle? (Rate from 1 to 10, with 10 being 100% committed).

What obstacles could prevent you from changing those lifestyle factors that are undermining your health?

What might stop you from following the therapeutic protocols that I may prescribe for you?

Do you believe there is a solution to your health concerns?

Do you believe you can be 100% healthy and pain-free?

What percent of improvement in your symptoms do you expect to notice?

FOR THE PAST 2 MONTHS:

Do you drink distilled water regularly?	
Where does your drinking water come from? (Well, city, bottled)	
Do you have a wireless router in your house?	
Do you use tobacco currently? Type? Were you previously a smoker? How much?	
Do you have any major scars on your body?	
Do you have bloating/gas?	
Do you have heartburn?	
Do you have at least one bowel movement a day?	
How long does it take to fall asleep?	
How many times during the night do you wake to use the restroom? Do you fall back to sleep easily?	
What time do you generally go to bed?	
What time do you generally wake up?	
Do you sleep on a memory foam mattress or pillow?	
Do you have body piercings? How many? Where?	
How many 8 oz. cups of caffeinated drinks to you consume a day? (Coffee, tea, soda, etc.)	
Do you get dizzy if you stand too quickly?	
How many headaches a week do you have?	
How many meals do you eat at a restaurant or take-out restaurant a week?	
Do you have a "sweet tooth?" □Yes □No	
Do you use a microwave? How often?	
Do you chew gum? What kind? How often?	
Do you live West of Kalispell? (Kila area?)	
How would you rate your energy on a scale of 1-10, with 10 being very good?	
How many pills of pain relievers do you take a week? (Tylenol, Ibuprofen, Aleve, aspirin or similar)	
Is your job associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents) and health and/or life threatening activities (e.g. fireman, etc.)?	
How many times in the **past 2 years** have you been on antibiotics, for any reason?	
How many times in your **lifetime** have you been on antibiotics?	

Patient's/Guardian's Signature:_____ **Date:** _____