Progressive Chiropractic Wellness Center
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PATIENT INFORMATION

Patient Name: Dr./Mr./Mrs./Ms. _____
Last Legal First Middle Initial

Name you prefer to be called (nickname):_____ Social Security #:_____

Phone #:(___)_____ Fax #:(___)_____Cell #:(___)_____

E-mail:_____

Address:_____ City:_____ State:___ Zip:_____

Age:_____ Birth Date: _____ Gender:_____ Patient's Employer: _____

Work Address: _____ City:_____ State:___ Zip:_____

Phone #: (___)_____Ext:_____ Occupation: _____

Please circle: single/married/domestic partners/divorced/other:_____ Spouse/partner's name:_____

PERSONAL HEALTH HISTORY

Have you seen Dr. Ezgur for anything before? No/Yes, explain:_____

Have you ever been to chiropractor before? No/Yes, what for?_____

Who referred you to our practice? Person: _____ Advertisement:_____

Are you, or might you be pregnant? No/Yes Do you have a pacemaker? No/Yes

What do you hope to do better or enjoy more when you regain your health?_____

_____

When was your last physical exam?_____Results:_____

_____

Date, and results, if known, of any recent tests: cholesterol:_____other:_____

Please list all current medications, vitamin/mineral supplements, herbs, including dosage (attach separate page if necessary):_____

_____

_____

_____

_____

If you smoke or have ever smoked, describe how much, and for how long:_____

Describe your recreational drug use:_____

Typical alcohol intake (#of drinks per day/per week):_____

Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.):_____

_____

_____

_____

Please list and describe all significant previous surgeries:_____

_____

_____

_____

Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:_____

_____

_____

Height:_____ Present Weight:_____ Weight one year ago:_____ Preferred Weight:_____

Any recent weight changes?:_____

SYMPTOM LIST

Please indicate which of the symptoms listed below that you have ever experienced, with the following coding system:

- ***"C" if you are currently experiencing this symptom***
- ***"R" if you tend to experience this symptom on a regular or recurring basis***
- ***"NW" if you've never fully recovered from (never been completely well since having this symptom)***
- ***"P" if you've experienced this symptom in the past***

GENERAL

_____Frequent or recurring Chills
_____Epilepsy/Convulsions/Seizure
_____Frequent or recurring Dizziness
_____Frequent or recurring Fainting
_____Frequent or recurring Fatigue
_____Frequent or recurring Fever
_____Headache
_____Frequent or recurring Sleep loss
_____Recent Weight Change
_____Anxiety/Panic Attacks
_____Depression
_____Frequent or recurring Sweats
_____Frequent/recurring hives/rashes
_____Frequent/recurring colds/flu
_____Vertigo
_____Fainting
_____Fears/Phobias

GENITO-URINARY/ENDOCRINE

_____Bedwetting
_____Frequent urination
_____Urinary tract infections
_____Painful urination
_____Painful menstruation
_____Prostate trouble
_____Loss of bowel/bladder control
_____Gall Stones
_____Blood in urine
_____Thyroid problems/Goiter
_____Kidney stones
_____Irregular menstrual cycle
_____Hot flashes
_____Diabetes
_____Pelvic Inflam. Dis.
_____Infertility/Miscarriage

RESPIRATORY

_____Spitting up phlegm
_____Chest pain
_____Spitting up blood
_____Difficult breathing
_____Asthma
_____Wheezing
_____Chronic cough
_____Allergies

GASTROINTESTINAL

_____Bloating, belching, gas
_____Esophageal reflux
_____Constipation
_____Frequent heartburn
_____Ulcer
_____Digestive Problems
_____Parasites
_____Pain over stomach
_____Diarrhea
_____Vomiting
_____Nausea
_____Poor appetite
_____Candida/Yeast
_____Hernia

CARDIOVASCULAR

_____Hardening of arteries
_____High blood pressure
_____Pain over heart
_____Bad circulation/ankle swell
_____Rapid heart beat
_____Heart Disease
_____Palpitation/Ireg heart beat
_____Cold Hands &/or Feet

EYES, EARS, NOSE, THROAT

_____Frequent/recurring sore throat
_____Deafness
_____Dental problems
_____Ear problems/Infections
_____Sinus problems
_____Frequent/recurring nose bleeds
_____Vision problems
_____Canker sores
_____Cold sores

MUSCULOSKELETAL – pain, numbness, weakness in:

_____Low Back
_____Neck
_____Upper Back
_____Mid Back
_____Between Shoulder Blades
_____Shoulder Blade: R/L both
_____Shoulder: R/L both
_____Foot: R/L bunions/corns
_____Fibromyalgia
_____Arm: R/L both
_____Elbow: R/L both
_____Hand: R/L both
_____Leg: R/L both
_____Hip: R/L both
_____Knee: R/L both
_____Ankle: R/L both
_____Spinal curvature
_____Arthritis/Gout

OTHER

_____Absesses
_____Acne
_____Alcohol/Drug Addiction
_____Anemia
_____Athlete'sFoot/Fungal infection
_____Cancer
_____Chicken Pox
_____Eczema
_____Genital Warts
_____Warts
_____Hepatitis
_____Scarlet Fever
_____HIV
_____Chicken Pox
_____Dry/Cracked heels

OTHER

_____Mononucleosis
_____Psoriasis
_____Sexually Transmitted Disease
_____Whooping Cough
_____Ingrown Toenails/Hang-nails

OTHER

_____Genital Herpes
_____Pnuemonia
_____Sexual Abuse
_____Worms
_____Teeth Problems/Cavities

OTHER

_____Mumps
_____Root Canal/gumdisease
_____Stroke
_____Shingles
___Penile/Vaginal Discharge

Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list any other symptoms that were not listed above: _____

_____

Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:

Symptom: _____ Family members also affected: _____

Symptom: _____ Family members also affected: _____

Symptom: _____ Family members also affected: _____

Symptom: _____ Family members also affected: _____

Please list any other significant health problems of parents, grandparents, or siblings: _____

_____

SPOUSE/PARTNER/FAMILY MEMBERS' OBSERVATIONS

If possible, it would be helpful to get any additional insight from your spouse, or other family members. Of importance are things difficult for one to observe of him or herself. This includes sleep behavior (snoring, talking, crying out during dreams, movements/positions, uncovering). Also useful are childhood behaviors, fears, traumas (physical or emotional), which might be remembered by a parent or older sibling.

Sleep behavior:_____

_____

_____

_____

_____

Childhood fears, behavior, trauma:_____

_____

_____

_____

_____

Any other observations:_____

_____

_____

_____

_____

NUTRITION

Which do you eat on a typical day: { }Breakfast { }Lunch { }Dinner # of snacks/day:_____

Please indicate the estimated number of servings of each of the following, which you eat on a typical day:

_____Eggs _____Red Meat _____Fruits _____Yogurt _____Tofu/Soy _____Fish
_____Cheese _____Spicy Foods _____Vegetables ___Grains,Rice,Pasta,Cereal,Bread _____Milk _____Bacon/Hot Dogs
_____Desserts _____Chicken/Turkey _____Margarine _____Nuts/Seeds/Peanut Butter _____Sausage/Lunch Meats
_____Regular Soft Drinks _____Water _____Regular Cofffee _____Decaf. Coffee _____Diet Soft Drinks
_____Fruit Juices _____Regular Tea _____ Decaf. Tea _____Herbal Tea _____Sports Drinks (i.e.,Gatorade)

On a scale of 1-10, (10 being perfectly healthy) how healthy would you rate your diet:_____

If you try to follow a special diet (i.e., low fat, low cholesterol, low calorie, low sodium, low carb, diabetic), please describe: _____

_____