ClearPoint WELLNESS

STATE OF HEALTH HISTORY

Name: _____ I like to be called: _____ Address City/Zip: _____

Date: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____ DOB:_____ Age: ___

Height: _____ Weight 1 yr ago/now: ___/___ Sex: M F TG Sexual Preference: M F Relationship Status: S M CP D W Cohabitate No. of children: _____

Occupation: _____ Hrs work/wk: _____ Have you been to a chiropractor before? Y N Have you seen a health or wellness practitioner in the last year? Y N

Email: _____ Emergency Contact: _____ Referred by: _____

REASON FOR CARE (Check all that apply and write brief description) ☐ wellness/proactive care ☐ imbalance _____
☐ condition _____ ☐ pain _____ ☐ disease _____ ☐ other _____

STRESSORS - Stresses from daily living you are, or have been, exposed to.

Check P (Past) and/or C (Current) where applicable.	P	C	Comments
Large Physical (Accidents, falls, sports, trauma, surgery, electric shock, fighting, difficult birth)			
Constant Physical (Repetitive Motion, poor posture, limp, sit/stand all day, computer work, carry child/heavy bag)			
Large Chemical: (Toxic Exposure, Serious Infections, hormonal changes, transplant)			
Constant Chemical: (Medication, allergens, new home, pollution, pesticides, implants)			
Large Mental/Emotional (Recent move/change in life, New Relationship/ Newly Married, death of relation, sense of danger, financial difficulty, separation from loved one, serious illness)			
Constant Mental/Emotional (Deadlines/ overworked, in a hurry, lack of sleep, negative attitude, skipped meals, abused/manipulated, sustained concentration, relationship issues, uncertain about future)			

LIST TOP PERSONAL STRESSORS IN LIFE NOW

1.
2.
3.
4.
5.

LIST TOP HEALTH ISSUES / GOALS

1.
2.
3.
4.
5.

HABITS THAT EITHER CREATE EASE OR MORE STRESS IN YOUR BODY: Mark an "x" on the line indicating if you are closer to adding stress to your body or relieving stress for each habit.

Ease		Stress
Drink >5 glasses of water/ day	_____	**D**rink coffee / sodas / alcohol
Eat whole foods (fruits, veg, grain, meats),olive oil / butter, balanced diet	_____	**E**at refined/processed foods (crackers, sweets, canned),fried foods/ hydrolyzed fat, same foods a lot
Exercise / Walk up stairs / Stretch	_____	**No** structured exercise/stretching weekly
Wear supportive shoes	_____	**W**ear shoes with little support or heels
Feel rested / sleep on side on good bed / use cervical pillow	_____	**U**n-rested / sleep on back or stomach on bad bed / unsupportive pillow
Take Time for yourself daily	_____	**A**lways working for others
Take breaks throughout day	_____	**W**ork continuously through day
Quality time w/ family/friends	_____	**N**o time to get together with people
Positive attitude / purpose	_____	**N**egative thoughts / aimless
Laugh at self	_____	**T**ake yourself seriously

Dr. Notes

↑ ↓ **Nuun Sub / Ad Fd ElimD Deliv**

B **Lg/Prot**
L **Ad Sn**
D **ImmLb**

Inj Rehab **Ad**
Fav Act **Sub**

Kar

NB /Pil/ Position/ Envir
Write /NoElec / Routine

SympRS

Alm

Grp

C /Met / Breath

How much energy do you have: (10 highest) Does it fluctuate daily? _____ What's your high and low 1/10? _____ What time is it high? _____
What time is it low?_____ Is your energy affected by food? _____ Is it affected by stress? _____

Dental History: ☐Recent work ☐Route Canals ☐ Braces ☐Caps/Veneers ☐ Whitening ☐Implants ☐ Bridges ☐Other

SYMPTOMS – Check if you are experiencing currently (C) or have experienced in the past (P).

Symptom	P	C	Symptom	P	C	Dr. Notes
1.Frequent infections			53.Abdominal pain			
2.Allergies			54.Liver issues			
3.Fatigue			55.Digestive Enzyme Issue			
4.Dizziness			56.Indigestion			
5.Meningitis			57.Ulcer			
6.Diabetes			58.Distention/"gassy"			
7.Thyroid			59.Inflammation of bowel			
8.Adrenal			60.Constipation			
9.Hormones			61.Loose stool/diarrhea			
10.Eye/visual problems			62.Change in bowel habits			
11.Difficulty hearing			63.Change in appetite			
12.Ringing in ears			64.Yeast infections			
13.Nose bleeds			65.Hernia			
14.Difficulty smelling			66.Flank/side pain			
15.Sinus irritation			67.Frequent urination			
16.Hoarseness/ Difficulty swallowing			68.Urinary urgency/hesitancy/pain			
17.Anxious or Depressed			69.Interstitial Cystitis			
18.Insomnia			70.Kidney Infection			
19.Difficulty relaxing			71.Strep infections			
20.Easily irritated/ difficulty focusing			72.Suppressed Immune System			
21.Get up during night			73.Auto immune condition			
22.Irritated by bright light			74.Hypersensitive to meds			
23.Neck stiff or painful			75.Sensitive to other's emotions			
24.Headaches			76.Sensitive to touch			
25.Seizures			77.Joint stiffness			
26.Other brain issues			78.Joint swelling/pain			
27.Difficulty chewing/TMJ			79.Bumps around joints			
28.Mind "races"			80.Shin splints			
29.Difficulty balancing			81.Groin pulls			
30.Numbness/tingling			82.Disc problems			
31.Muscle stiffness/pain			83.Sciatica			
32.Muscle weakness			84.Stenosis			
33.Difficulty breathing			85.Hip/Knee problems			
34.Persistent Cough			86.Pain in ball of foot			
35.Wheezing/asthma			87.Other foot problems			
36.Pulmonary issues			88.Shoulder/Arm/Hand			
37.Shortness of breath			89.Low back Pain			
38.Chest discomfort			90.Rib cage distortion			
39.Ankle swelling			91.Tendonitis			
40.Sudden calf pain			92.Scoliosis			
41.High blood pressure			93.Arthritis of spine			
42.Other heart issues			94.Sports Injuries			
43.Stroke			95.Motor Vehicle Accidents			
44.Blood clots			96.Major scars			
45.Heartburn/reflux			97.Tumor / Growth			
46.Food sensitivities			98.Mole changes			
47.Rash/itching			99.Weight loss/gain			
48.Anemia			100.Cancer			
49.Hepatitis			101.Change in nails or skin			
50.Jaundice			102.Loss of flexibility			
51.Gall Bladder Issues			103.Loss of strength			
52.Nausea/vomiting			104.Exposure to Mold			

Women		Men	
Date of last menstrual period		Prostate condition	
Regular or Irregular periods? Flow?		Diminished urinary flow?	
Are you pregnant or trying to get pregnant?		Sexual dysfunction	
Pelvic Pain / Endometriosis / Hormonal imbalance		Testosterone imbalance	
Hysterectomy / Endometrial Ablation		Are you trying to have a baby?	

List accidents, falls, fractures, sprains, strains, hospitalizations & surgeries	List medications/supplements – Why taking them

Allergies: _____

Family History of Disease: _____

Personal History of Disease or Chronic Condition: _____

Anything else you would like to add? _____

Dr.'s Notes

Eye ex Adren Horm Symp Immune Sinus TMJ Moles Labs Refs _____