

The Wellness Center

Dr. Phil Gilbert, D.C.

Dr. Nancy Owens, D.C.

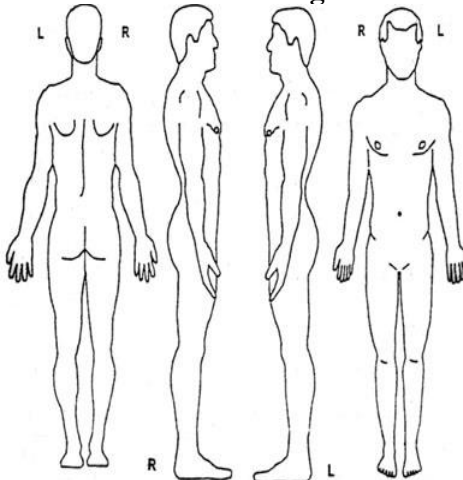
Name: _____ Date: _____

Welcome to the Wellness Center.

History of Present Complaint

1. What is your major complaint? _____
2. Date of onset _____ Gradual or sudden onset? _____
3. Is this condition due to an Auto Accident Work Injury Other Accident Unknown cause Illness
4. What is the severity of pain/discomfort on a scale of 0-10 (0 is no pain, 10 is the worst you have ever experienced) _____
5. How long does an episode last approximately? Minutes Hours Intermittent Constant
6. When do you notice it most? AM/PM _____
5. Other complaints? Please describe: _____
6. Are the symptoms: Improving Getting worse About the same Intermittent (come and go)
7. What makes it better? _____ What makes it worse? _____
8. Type of pain: sharp dull aching burning throbbing cramping numbness tingling other: _____
9. Have you had these symptoms before? _____ If so, when? _____
10. Do you have any difficulty performing any of the following activities: (circle all that apply)
 Personal Care – Lifting – Reading – Working – Driving – Walking – Sitting – Standing – Social Life - Exercise
11. Have you seen another doctor for this condition? _____ Dr.'s Name & Location: _____
 Date consulted _____ Diagnosis _____

Please mark areas of pain on the drawing



Family History (Please put appropriate symbol in each box that applies to family history) F = Father M = Mother S = Sister B = Brother

Diabetes	Cancer	Heart	Bld. Pres.	Chol.	Kidney	Scoliosis	Back Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Depression	Nerves	Rheum. Arth.	MS	Psoriasis	Asthma	Thyroid	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Chemical Sensitivity	Atopic Dermatitis	Cause of death:
<input type="checkbox"/>	<input type="checkbox"/>	Mother: _____
<input type="checkbox"/>	<input type="checkbox"/>	Father: _____
<input type="checkbox"/>	<input type="checkbox"/>	Brother: _____
<input type="checkbox"/>	<input type="checkbox"/>	Sister: _____

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Name: _____ Date: _____

Please complete the following review of your health picture.
While these conditions may not seem directly related to the reason you are here,
this information will help the doctor get a better idea of your overall health, past and present.
Please indicate any conditions that you have presently, or have had in the past, with the onset year.

Childhood Illnesses:

ADD/ADHD Allergies Anemia Asthma Bedwetting Cerebral Palsy Diabetes
 Ear Infection Fetal Drug Exposure Food Allergies: _____
 Headaches Measles Mumps Psoriasis Scoliosis Seizures Spina Bifida

Adult Illnesses:

Alzheimer's Anemia Arthritis Asthma Cancer Crohn's/colitis CVA (stroke)
 Cystic kidney disease Depression Diabetes (insulin dep./non insulin dep.) Eczema
 Emphysema Eye Problems Fibromyalgia Heart Disease Hepatitis HIV
 Hypertension Liver Disease Lung Disease Lupus Multiple Sclerosis Parkinson's
 Pneumonia Psoriasis Psychiatric concerns Scoliosis Seizures Shingles
 STD Suicide attempt(s) Thyroid problems Vertigo Other: _____

Injuries: (Please list date and explanation)

Back injury Broken bones Head injury Loss of consciousness Industrial accident
 Joint injury Auto Accident (Date(s) _____) Laceration
 Other: _____
Explanation _____

Surgeries: (Please list any surgeries you have had with the date)

Tonsillectomy Appendectomy Gall Bladder Back surgery Tubes in ears Female Organs
 Rectal Surgery Other: _____

Medications & Vitamins: (Please list your current medications and vitamins and the dosages)

Do you have any known adverse drug reactions? _____

Females ONLY:

Pregnancy History:

of complicated pregnancies # of uncomplicated pregnancies # of C-Sections
 # of vaginal deliveries # of miscarriages # of terminated pregnancies

Menstrual History:

regular irregular age of first menses age when menopause began

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Review of Systems

Often seemingly unrelated complaints that you might not think to mention indicate a pattern in the bigger picture of holistic health. Please check accordingly:

1= Previously experienced 2= Occasionally experienced 3= Presently experienced 4= Presently severe

<u>General Symptoms</u>	1	2	3	4	<u>Gastro-intestinal</u>	1	2	3	4	<u>Eye/Ear/Nose/Throat</u>	1	2	3	4
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness R/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Noises (Tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/pain of arms/legs/hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastritis/Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Muscles & Joints</u>	1	2	3	4	<u>Skin or Allergies</u>	1	2	3	4	<u>Respiratory</u>	1	2	3	4
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Eruptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twitching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruising easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Spinal Curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
Pain betw. Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
<u>Cardiovascular</u>	1	2	3	4	<u>Genito-Urinary</u>	1	2	3	4	<u>Female Conditions</u>	1	2	3	4
Rapid Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequ. Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pres.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain over Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps or Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prev. heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to					Vaginal Yeast Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	control urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										

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Name: _____ Date: _____

Tests and Immunizations (Please provide approximate dates)

Blood Profile _____	HIV Test _____
Breast Exam _____	PAP Smear _____
Breast Mammography _____	Pneumonia Vaccine _____
CBC _____	Pulmonary Function _____
Chest X-Ray _____	Rectal Exam _____
Cholesterol, Triglycerides _____	Sigmoidoscopy _____
Complete Physical _____	Sodium & Potassium _____
EKG _____	Stool, Occult Blood _____
Enlarged Heart _____	Tetanus (DPT) _____
Flu Shot _____	Treadmill Test _____
Genitalia Exam (Male) _____	Urinalysis _____

Social History

- Do you use tobacco products? Y/N What type? _____ How much per day? _____
- Do you drink alcohol? Y/N What kind? _____ How much per week? _____
- Do you drink coffee? Y/N How many cups per day? _____
- Do you drink sodas? Y/N How many cups per week? _____
- Any other types of stimulants? Y/N What kind? _____ How much per week? _____
- Do you exercise? None Occasional Weekly Daily Details: _____
- How well do you sleep and in what position? _____
- What level of lifestyle stress would you estimate you have? (0-10, 0=no stress, 10=the worst you ever had)

The above information is complete and accurate to the best of my knowledge.

Patient's signature _____ Date _____