Optimal Wellness Solutions

2489 Rice Street, Suite 130
Roseville, MN 55113
651-340-1233

NEW CLIENT HEALTH HISTORY FORM

Date _____

General Details

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Date of Birth _____ Age _____

Occupation _____ Marital Status _____

Number of Children _____ How did you discover my office and the professional services I offer? _____

_____

Health Care History

Have you ever had your spine and/or nervous system examined professionally? ☐ Yes ☐ No

If yes, when and by whom? _____

What diagnosis and treatments were suggested? _____

What is your current primary health concern? Please describe: (what, where, when, for how long, etc.): _____

_____

Please place an "X" next to any of the following concerns or symptoms you have:

____ Neck problems	____ Broken Bones	____ Allergies	____ Shoulder problems
____ Hay fever	____ Muscle cramps	____ Arm problems	____ Asthma
____ Weak muscles	____ Headaches	____ Anxiety	____ Eczema
____ Pain between shoulders	____ Dizziness	____ Shingles	____ Low back problems
____ Fainting	____ Poor digestion	____ Leg problems	____ Depression
____ Diarrhea	____ Numbness in legs	____ Forgetfulness	____ Ulcers
____ Numbness in arms	____ Vision problems	____ Constipation	____ Stiff joints
____ Ear pain/noises	____ Kidney infection	____ Painful joints	____ Ear infections
____ Menstrual cramps	____ Restricts daily activities	____ Hearing loss	____ Diabetes
____ Restricts regular exercise	____ Frequent colds	____ Blood pressure	

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Please tick which of the following you have tried; and put "S"(Successful) or "U" (Unsuccessful) next to them to indicate what sort of results you had.

____ Chiropractic	____ Homeopathy	____ Rebirthing	____ Massage/Body work
____ Naturopathy	____ Breathwork	____ Emotional therapy	____ Oriental medicine
____ Yoga/movement/dance	____ Psychotherapy	____ Acupuncture	____ Tai chi/Qigong
____ Osteopathy	____ Nutritional counseling	____ NLP/NCP/ The forum	____ Cranial work
____ Oxygen therapy	____ SRI	____ Physical therapy	____ Chelation therapy
____ Other	____ Occupational therapy	____ Reiki	____ Somato respiratory integration

Spinal Cord Tension results from the body's inability to adapt to physical, chemical, and mental/emotional stress. Therefore, it is extremely helpful for your practitioner to know as much as possible about your past and present stresses in these categories.

Physical Stress

During the day I: ☐ Sit ☐ Stand ☐ Walk ☐ Desk work ☐ Phone work ☐ Drive ☐ Do heavy lifting

I exercise: ☐ Daily ☐ Weekly ☐ Monthly Describe: _____

Were you or are you active in any particular sport(s)? ☐ Yes ☐ No

Which one(s) presently? _____

Which one(s) in the past? _____

Have you been hurt in any of these activities? ☐ Yes ☐ No

What were the injuries? _____

Please answer these questions with as much detail as possible:

Have you ever (even as a passenger, even if you don't think you were hurt) been involved in a vehicular collision? Please list approximate dates, type of accident and severity (mild, moderate, extreme).

Automobile: _____

_____

Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

_____

Major falls as a child or adult: _____

Head trauma/ concussions (diagnosed or undiagnosed), loss of consciousness?: Please describe: _____

_____

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Medical Treatment

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, what was actually done to you and when? Please describe: _____

_____

Have you had surgery? ☐ Yes ☐ No

What was done to you and when? _____

Have you had:

____ Spinal tap
____ Spinal injections
____ Rebirthing
____ Neck collar
____ Spinal brace
____ Traction
____ Heel lift
____ X-rays taken
____ Radiation therapy
____ Psychotherapy
____ Acupuncture
____ Tai chi/Qigong
____ Osteopathy
____ Transfusions
____ Chemotherapy
____ Corrective shoes or bars on shoes
____ Body part in a cast or immobilized

Women, please describe your menstrual cycle (ie. regularity, discomfort, use of pain killers and oral contraceptives, etc.):

_____

Women, any history of uterine fibroids, endometriosis, ovarian cysts, hysterectomy, or infertility: _____

Birth stress: Please describe your birth (normal, forceps, C-section, etc.): _____

_____

Any chance your mother would have been on heavy medication or smoking while she was pregnant with you? _____

General Chemical Stress

Are you now taking any drugs (prescription, over the counter, or other)? ☐ Yes ☐ No

Please list drugs, if prescribed, when prescribed and reason for taking them: _____

_____

Significant childhood illnesses (frequent ear infections, etc.)? Heavy antibiotic use as a child or adult? _____

_____

Do you, or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? ☐ Yes ☐ No

Please describe: _____

Please describe your diet: _____

Please list any nutritional supplements you take: _____

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Emotional Stress

Please check "Yes" or "No" to indicate any of the following mental/emotional stress situations that apply to you presently or significantly in the past, and circle the level of intensity:

	Past	Present		Please Explain
Work or school stress	☐ Yes ☐ No	☐ Yes ☐ No	Mild Moderate Extreme	
Family or home stress	☐ Yes ☐ No	☐ Yes ☐ No	Mild Moderate Extreme	
Personal relationships	☐ Yes ☐ No	☐ Yes ☐ No	Mild Moderate Extreme	
Loss of loved one	☐ Yes ☐ No	☐ Yes ☐ No	Mild Moderate Extreme	
Lifestyle changes	☐ Yes ☐ No	☐ Yes ☐ No	Mild Moderate Extreme	
Changes in vocation	☐ Yes ☐ No	☐ Yes ☐ No	Mild Moderate Extreme	
Abuse (verbal/physical/sexual)	☐ Yes ☐ No	☐ Yes ☐ No	Mild Moderate Extreme	
Stress of commuting	☐ Yes ☐ No	☐ Yes ☐ No	Mild Moderate Extreme	

How do you grade your mental/emotional health? Please check one below:

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Improving ☐ Worsening

Which of the following 5 choices is currently of most interest to you? (Use the scale below to answer)

A) Very important to me B) Important to me C) Not So important D) Does not apply

☐ A ☐ B ☐ C ☐ D: Improvement of my physical symptoms

☐ A ☐ B ☐ C ☐ D: Improvement of my emotional/mental symptoms

☐ A ☐ B ☐ C ☐ D: Improvement of my ability to react or respond to stress (physical, chemical, mental)

☐ A ☐ B ☐ C ☐ D: Improvement of my enjoyment of life and the ability to make constructive choices

☐ A ☐ B ☐ C ☐ D: Overall improved quality of life

Is there anything else that you would like to tell me? _____

_____

_____

Thank you for filling out this form as it will assist in offering you a better service.

Practitioner's Notes:

_____

_____

_____

_____

_____

_____