GLOBAL WELLNESS CLINIC, P.C.

Paul L. Peters, D.C., D.A.C.B.S.P.
Matthew A. Wilson. D.C.
201 W. 2nd St., Madrid, IA 50156 – (515) 795-3655

Initial Health History Form

Name: _____ Date:_____
Address:_____ Phone:_____
Medical Doctor _____ Previous Chiropractor _____

Global Wellness Clinic's objective is different from an Allopathic's (M.D./D.O.) objective. Our objective is not to just identify and treat a condition, rather but additionally identify and correct subluxations.

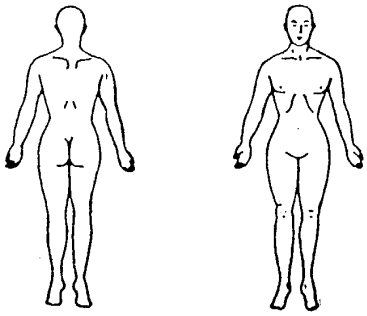
If you have no condition and are seeking chiropractic care to optimize body function and performance, skip to Section II.

Section I

Present complaint (brief) _____
Date started _____
Do you know what may have started it? _____
What aggravates condition/pain? _____
What lessens condition/pain? _____
Is condition worse during certain times of day? _____
Is condition interfering with work? _____
Is condition getting progressively better, worse, no change? _____
Has this problem interrupted your sleep ☐ Yes ☐ No How?_____
Have you seen a doctor for this condition? _____ When? _____
What tests did you have? _____
What diagnosis did they give? _____
What treatment did you receive? _____

Difficulty in:	☐ Standing	☐ Sitting	☐ Bending	☐ Walking	☐ Lying	☐ Other
Cannot lift:	☐ Light	☐ Moderate	☐ Heavy	☐ Repetitive		
Have Experienced:	☐ Dizziness ☐ Fainting	☐ Unsteadiness ☐ Pins & Needles	☐ Shortness of Breath ☐ Double Vision		☐ Chest Pain ☐ Bowel/Bladder Difficulty	

Rate your condition by circling number (0 1 2 3 4 5 6 7 8 9 10)
(none----------worse)



← Locate exact point of pain on picture.

Is the pain Sharp _____ Dull _____ Constant _____ Off & On _____

OVER→

Section II

Did/Do you smoke? _____
Do you drink pop? _____
Do you wear Orthotics? ☐ Yes ☐ No
Past auto accidents? _____
Injuries? _____
Fractures (broken bones)? _____
Teeth, eyes, or hearing problems? _____
Do you have occupational stress? _____
Do you have physical stress? _____
Do you have mental stress? _____
Surgeries (Please list all) _____
Current medications _____
Past medical history _____
Allergies _____

Family History	Heart	Arthritis	Cancer	Diabetes	Other
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____

In your visits here we want to know what one activity in your life you are unable to do or having the most difficulty with as a result of your chief problem.

Please list 1 activity you are unable to perform or having the most difficulty with because of your chief problem.

1. _____

<u>Activity #1</u>

Patient Specific Activity Scoring scheme (Circle the number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

Able to perform activity at same level as before injury or problem

Our goal is to work together with you to "problem solve" ways to return you to the activities which you have told us you are either unable to perform or are giving you the most difficulty since the problem began.

To the best of my knowledge, all statements in the above Health History are true.

Signed _____ Date _____
(If patient is under 18 years, parent must sign)