JS Wellness
acupuncture herbs nutrition yoga

JS Wellness LLC
665 Newark Ave, Suite 406
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Community Chiropractic
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Please note: *This is a confidential record of your medical history and will be kept in this office. Information contained here will be not released to any person except when you have authorized us to do so. This is document is form fillable so it can be completed on your computer and then printed out.*

Date: _____ **First Name:** _____ **M.I.** ____ **Last Name:** _____

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

Home Phone: _____ **Cell:** _____ **Work**: _____ ☐ **Male** ☐ **Female**

Email: _____ **Date of Birth:** _____ **Age:** _____

Occupation: _____ **Education:** _____

☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Partner** **Spouse/Partner Name:** _____

Emergency Contact: _____ **Telephone:** _____

Referred by: _____

Goals: What would you like to achieve through your work here?

1) _____

2) _____

3) _____

Major Symptoms: Please list in order of importance what symptoms are of concern to you (most concerning to least with duration of symptoms)

1) _____

2) _____

3) _____

Medical History (Please check all that apply):

	Condition	Date Diagnosed
☐	Diabetes	
☐	High Blood Pressure	
☐	Thyroid Disease	
☐	Cancer	
☐	HIV	

	Condition	Date Diagnosed
☐	High Cholesterol	
☐	Seizures	
☐	Hepatitis	
☐	Other	
☐	Other	

Surgical History:

_____ **Date:** _____

_____ **Date:** _____

Family History
Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Grandparent
Heart disease				
Cancer				
Hypertension				
Stroke				
Asthma				
Allergies				
Migraines				
Depression				
Other mental illness				
Substance abuse				
Osteoporosis				
Diabetes				
Glaucoma				

Medications / Supplements
Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies (to medications, chemicals or foods):
_____ _____ _____
_____ _____ _____

Nutrition

Do you follow a special diet? ☐ Yes ☐ No If yes, how would you describe the diet?
(ie Vegetarian, Vegan, Low Carb, etc.)
_____
What do you eat on a "typical" day? _____
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Foods you tend to crave: _____
Foods you dislike: _____

Social History
1. How much per day do you use of the following?
a) Coffee, tea, soft drinks:_____
b) Alcohol:_____
c) Cigarettes, cigars, other tobacco:_____
d) Other drugs: _____

For Women:
Are you pregnant now? [ ]Yes [ ]No [ ]Unsure
Indicate number of occurrences:
Live Births _____ Pregnancies_____ Miscarriages _____ Abortions _____
Age: First period _____ Menopause (if applicable) _____
Date: Last Pap Smear _____ /_____ Last Mammogram _____ / _____
Any History of an Abnormal Pap Smear? [ ] Yes [ ] No If so, what / when? _____

For Men:
Do you have any bothersome urinary symptoms? [ ] Yes [ ] No
Describe:_____

Exercise
Please describe your current exercise regimen:

Hours per week: _____ Activities: _____ [ ] No Exercise

Sleep
How many hours of sleep do you usually get per night during the week? _____

Do you awake feeling rested? [ ] Yes [ ] No Do you feel you sleep well at night? [ ] Yes [ ] No

Other Information
Please list and briefly describe any other information that might be important

HEALTH: CHECK ALL THAT APPLY

GENERAL

Past	Current	Condition
☐	☐	Poor appetite
☐	☐	Excessive appetite
☐	☐	Insomnia
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Night sweats
☐	☐	Sweat easily
☐	☐	Chills
☐	☐	Localized weakness
☐	☐	Poor coordination
☐	☐	Bleed or bruise easily
☐	☐	Catch cold easily
☐	☐	Change in appetite
☐	☐	Strong thirst
☐	☐	Other: _____

SKIN & HAIR

Past	Current	Condition
☐	☐	Rashes
☐	☐	Hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Pimples
☐	☐	Dryness
☐	☐	Tumors, lumps
☐	☐	Hair loss

HEAD & NECK

Past	Current	Condition
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Neck stiffness
☐	☐	Enlarged lymph glands
☐	☐	Headaches
☐	☐	Concussions
☐	☐	Other: _____

EARS

Past	Current	Condition
☐	☐	Infection
☐	☐	Ringing
☐	☐	Decreased hearing
☐	☐	Other: _____

EYES

Past	Current	Condition
☐	☐	Blurred vision
☐	☐	Visual changes
☐	☐	Poor night vision
☐	☐	Spots
☐	☐	Cataracts
☐	☐	Glasses / contacts
☐	☐	Eye inflammation
☐	☐	Other: _____

NOSE, THROAT, MOUTH

Past	Current	Condition
☐	☐	Nose bleeds
☐	☐	Sinus infections
☐	☐	Hay fever or allergies
☐	☐	Recurring sore throats
☐	☐	Grinding teeth
☐	☐	Difficulty swallowing

CARDIOVASCULAR

Past	Current	Condition
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Blood clots
☐	☐	Palpitations
☐	☐	Phlebitis
☐	☐	Chest pain
☐	☐	Irregular heart beat
☐	☐	Cold hands / feet
☐	☐	Fainting
☐	☐	Difficult breathing
☐	☐	Swelling of hands / feet
☐	☐	Other: _____

RESPIRATORY

Past	Current	Condition
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Frequent colds
☐	☐	Chronic obstructive
☐	☐	Pulmonary disease
☐	☐	Pneumonia
☐	☐	Cough
☐	☐	Coughing blood
☐	☐	Production of phlegm
☐	☐	Other: _____

GASTRO-INTESTINAL

Past	Current	Condition
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Belching
☐	☐	Blood in stools/black
☐	☐	Stools
☐	☐	Bad breath
☐	☐	Rectal pain
☐	☐	Hemorrhoids
☐	☐	Constipation
☐	☐	Pain or cramps
☐	☐	Indigestion
☐	☐	Gall bladder disorder
☐	☐	Gas
☐	☐	Bloating
☐	☐	Other: _____

GENITO-URINARY

Past	Current	Condition
☐	☐	Kidney stones
☐	☐	Painful urination
☐	☐	Frequent urination
☐	☐	Blood in urine
☐	☐	Urgency to urinate
☐	☐	Unable to hold urine
☐	☐	Night Urination
☐	☐	Other: _____

MALE

Past	Current	Condition
☐	☐	Pain / itching genitalia
☐	☐	Genital lesions/ discharge
☐	☐	Impotence
☐	☐	Weak urinary stream
☐	☐	Lumps in testicles
☐	☐	Other: _____

FEMALE

Past	Current	Condition
☐	☐	Frequent urinary tract infections
☐	☐	Frequent vaginal infections
☐	☐	Pain / itching of genitalia
☐	☐	Genital lesions / discharge
☐	☐	Pelvic inflammatory disease
☐	☐	Abnormal pap smear
☐	☐	Irregular menstrual periods
☐	☐	Painful menstrual periods
☐	☐	Premenstrual syndrome
☐	☐	Abnormal bleeding
☐	☐	Menopausal Syndrome
☐	☐	Breast lumps
☐	☐	Hot flashes
☐	☐	Other: _____

NEUROLOGICAL

Past	Current	Condition
☐	☐	Seizures
☐	☐	Tremors/Motor Ticks
☐	☐	Numbness/tingling of limbs
☐	☐	Concussion
☐	☐	Pain
☐	☐	Paralysis
☐	☐	Other: _____

PSYCHOLOGICAL

Past	Current	Condition
☐	☐	Depression
☐	☐	Anxiety / stress
☐	☐	Irritability
☐	☐	Treated for emotional or
☐	☐	Psychological problems
☐	☐	Other: _____

INFECTION SCREENING

Past	Current	Condition
☐	☐	HIV
☐	☐	TB
☐	☐	Hepatitis
☐	☐	Gonorrhea
☐	☐	Chlamydia
☐	☐	Syphilis
☐	☐	Genital warts
☐	☐	Herpes: oral
☐	☐	Herpes: genital

MUSCULAR-SKELETAL

Past	Current	Condition
☐	☐	Stiff neck / shoulders
☐	☐	Low back pain
☐	☐	Back pain
☐	☐	Muscle spasm, twitching, cramps
☐	☐	Sore, cold or weak knees
☐	☐	Joint pain

HEALTH INSURANCE INFORMATION

Insured's Name: _____

Insurance Company Name: _____ **Policy #:** _____

Insurance Company Address: _____

City, State, Zip: _____ **Phone:** _____

MEDICARE INFORMATION

Insured's Name: _____

Insurance Company Name: _____ **Policy #:** _____

Insurance Company Address: _____

City, State, Zip: _____ **Phone:** _____