

# 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.

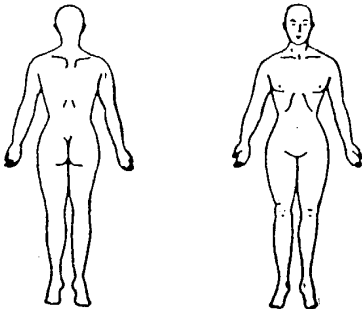
**If you have no condition and are seeking chiropractic care to optimize body function and performance, skip to Section II.**

### 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? \_\_\_\_\_

<b>Difficulty in:</b>	<input type="checkbox"/> Standing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Bending	<input type="checkbox"/> Walking	<input type="checkbox"/> Lying	<input type="checkbox"/> Other
<b>Cannot lift:</b>	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy	<input type="checkbox"/> Repetitive		
<b>Have Experienced:</b>	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Unsteadiness	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Chest Pain		
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Pins & Needles	<input type="checkbox"/> Double Vision	<input type="checkbox"/> 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 \_\_\_\_\_

<b>Family History</b>	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. \_\_\_\_\_

**Activity #1**

**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)