TURACK CHIROPRACTIC & performance health

10850 Perry Highway Wexford, PA 15090 724.940.3499 www.turackchiro.com

Date: _____ Insurance: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____

Age: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Status:

☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Single
☐ Partnership

Live with:

☐ Spouse
☐ Partner
☐ Parents
☐ Children
☐ Friends
☐ Alone

Education: _____

Occupation: _____ Hours per week: _____ ☐ Retired

Employer	Work Address

In case of emergency, who should we contact?

Name	Relationship	Address	Phone

How did you hear about our Wellness and Nutrition Program?

_____

_____

_____

What is your major complaint and when did these symptoms begin?

_____

_____

_____

What are your current medications?

What are your current vitamins and/or supplements?

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.)

Is there anything in your medical history that you consider to be relevant?

What is your employment history? Please provide brief summary.

Please list past or present allergies, including allergies to medications.

Please list all past surgeries and the condition each surgery was for.

Please explain your housing history (type of homes, where and when).

Patient History

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

Mercury

☐ Yes	☐ No	Do you have amalgam (silver) fillings in your teeth?
☐ Yes	☐ No	Have you ever had them in the past?
☐ Yes	☐ No	Did your mother have amalgam when pregnant with you?
☐ Yes	☐ No	Have you ever worked in a dental office? If so, how long? _____
☐ Yes	☐ No	Have you had any dental crowns, bridges, root canals, dry sockets or infected tooth extractions?
☐ Yes	☐ No	Do you have any dental implants or other metal in your mouth?
☐ Yes	☐ No	Did you wear contact lenses during the 1980's or early 1990's?
☐ Yes	☐ No	Did you take oral contraceptives during the 1980's or early 1990's?
☐ Yes	☐ No	Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
☐ Yes	☐ No	Have you noticed any adverse reactions to these shots?
☐ Yes	☐ No	Do you have any tattoos with red ink?
☐ Yes	☐ No	Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

Lead

☐ Yes	☐ No	Does your occupation involve soldering, metal salvage, old home repair or sandblasting?
☐ Yes	☐ No	Have you remodeled a home built before 1978?
☐ Yes	☐ No	Have you lived in a home built before 1978 for more than 5 years?
☐ Yes	☐ No	Have you ever worn cosmetics containing kohl?

General Toxicity

☐ Yes ☐ No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.

☐ Yes ☐ No Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)

Mold

How old is the house you are living in? _____ How long have you lived there? _____

☐ Yes ☐ No Do you see mold growing at home, work or school?

☐ Yes ☐ No Have you ever had water damage at home, work or school?

☐ Yes ☐ No Does your home, workplace or school have a damp or mildew smell?

☐ Yes ☐ No Does spending time in your basement cause or worsen your symptoms?

☐ Yes ☐ No Does your basement ever get wet?

☐ Yes ☐ No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?

Lyme Disease

☐ Yes ☐ No Have you ever been diagnosed with Lyme disease?

☐ Yes ☐ No Have you ever been bitten by a tick or recluse spider?

☐ Yes ☐ No Have you ever seen a bulls-eye rash appear on any part of your body?

☐ Yes ☐ No Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?

☐ Yes ☐ No Was your mother ever diagnosed with Lyme Disease?

☐ Yes ☐ No Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

Health History

☐ Yes ☐ No Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?

☐ Yes ☐ No Do you have any history of kidney dysfunction?

☐ Yes ☐ No Is there a family history of breast, uterine, cervical or other female cancers?

☐ Yes ☐ No Is there a family history of PMS, fibroids or ovarian cysts?
(Please circle all that apply)

☐ Yes ☐ No Do you have any history of heart disease, myocardial infarction (heart attack), etc.?

☐ Yes ☐ No Are you currently having any thoughts of suicide?

☐ Yes ☐ No Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?

☐ Yes ☐ No Do you have a history of strokes?

☐ Yes ☐ No Have you ever been diagnosed with diabetes mellitus?

☐ Yes ☐ No Have you ever been in an auto accident, fallen or received a major physical injury?

☐ Yes ☐ No Are you in menopause?

☐ Yes ☐ No Do you have any allergies to food or medication?

Name: _____ Date: _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

0 = Never had the symptom
1 = Occasionally have it, mild effect
2 = Occasionally have it, severe effect
3 = Frequently have it, mild effect
4 = Frequently have it, severe effect

Column #1

	Anxiety
	Mood swings
	Enraged behavior or anger for no reason
	Excessive shyness, timidity, social phobia (not typical to your personality)
	Irritability (not typical to your personality)
	Low body temperature (below 97.5°)
	Insomnia (can't get to sleep or return to sleep
	Dizziness
	Sound in ears (ringing or hearing your heart beat)
	Psychological symptoms, even thoughts of suicide
	Sensitivity to sound

	Indecisiveness
	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Floaters, shadows or swimmers when you read or look into the sky
	Dyslexia or loss of place while reading, even as a child
	Swelling eyelids
	Peeling on top layer of skin (hands, feet)
	Dry skin
	Heart pain (angina) and you are under 45 years old
	Depression
	Gout (arthritic pain, especially in big toes)
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muscles
	Hair falls out (not normal male pattern baldness)

Column #2

	Sensitivity to light
	Fatigue after exercising (feeling worse)
	Bad night vision or seeing halos around lights
	Shortness of breath, with very little effort
	Excessive thirst and/or frequent urination
	Red eyes or tearing
	Blurred vision at times
	Morning stiffness
	Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Chronic fatigue or weakness
	Non-restful sleep

	Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
	Trouble processing new information
	Word reversal or trouble finding words
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry non-productive cough
	Muscle twitching
	Excessive sweating, especially at night
	Joint pain-not necessarily true arthritis-can move from joint to joint
	Difficulty losing weight regardless of diet or exercise
	Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
	Frequent illness, prolonged illness or sick days
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing numbers in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Frequent muscle aches, cramps, unusual sharp sudden pains
	Rashes or rosacea
	Cold extremities (hands and feet)

	Total Columns 1 & 2