JBS WELLNESS
CHIROPRACTIC · NUTRITION · ENERGY

731 S. IL. RT. 21 Suite 140 | Gurnee, IL 60031 | (847) 680-9200 | www.JBSWellness.com

ADULT NEW PATIENT HEALTH HISTORY

Name: _____ DOB: _____ Date: _____

Primary Concerns/Goals: 1. _____

2. _____ 3. _____

When did it start and what therapies have you tried for it? _____

List all medications currently taking? _____

List all supplements currently taking? _____

Vegetarian? **Y / N** *Type:* _____ Metal in your body (fillings, staples, pins, etc)? **Y / N** _____ Blood type: _____

Allergies? **Y / N** Details: _____

Car Accidents? **Y / N** Details: _____

Hospitalizations / Surgeries? **Y / N** Details: _____

Hx of Head Trauma/Concussion/Spinal Trauma? **Y / N** Details: _____

Broken Bones / Dislocations? **Y / N** Details: _____

Hx of Abuse: Y / N ☐Physical ☐Mental ☐Emotional ☐Sexual _____

Family Hx of Disease (Diabetes, Heart Disease, Cancer, etc): _____

OFFICE USE ONLY Previous Chiropractic Care: **Y / N** Last visit: _____

pH: _____ Zinc test: _____ Ear Crease: _____ R _____ L Nails: _____ Tongue: _____

Height: _____ Weight: _____ Resist: _____ React: _____

Mark "C" for CURRENT problems and "P" for problems you've had in the PAST

___ Ulcer
___ Hiatal Hernia
___ Food intolerance: _____
___ Chrons / Colitis / IBS
___ Asthma
___ URI / Bronchitis ____x
___ Pneumonia ____x
___ Emphysema
___ Ear Infections ____x
___ Strep throat ____x
___ Root Canal(s) ____x
___ Staph infection / MRSA
___ Mononucleosis
___ Measles / Mumps
___ Autoimmune Disease:
Type: _____
___ Diabetes: Type: _____
___ Low Thyroid
___ Neurological problems:
Type: _____

___ Cancer: Type: _____
___ Learning Disability
___ Addiction: _____
___ Eating Disorder: _____
___ Eye problems: _____
___ Near-sighted / Far-sighted
___ Sleep Apnea / CPAP use
___ Insomnia
___ Osteoporosis / Osteopenia
___ Arthritis: _____
___ Gout
___ Psoriasis / Eczema
___ Varicose / Spider Veins
___ Heart issues: _____
___ High / Low Blood pressure
___ High Cholesterol
___ Stroke
___ Incontinence
___ Kidney stones
___ STD: _____

MALE ONLY

___ Infertility
___ Benign Prostatic Hyperplasia
___ PSA # _____

FEMALE ONLY

___ Birth control: _____
___ Infertility
___ Endometriosis
___ Fibrocystic Breast
___ Uterine fibroids
___ Ovarian cysts
___ Yeast Infection
___ Pelvic Inflam Disease
___ Abnormal Pap
___ Menopause
___ PCOS
Y / N Are you pregnant? ____ wks
Y / N Are you trying to be pregnant?
___ #Live birth ___#Pregnancies

TRAVEL HISTORY

___ Mexico / Central America
___ India / Southeast Asia
___ Africa

PAIN/STIFFNESS/SWELLING NUMBNESS/TINGLING

___ TMJ (R / L)
___ Neck (R / L)
___ Upper Back (R / L)
___ Shoulders (R / L)
___ Elbows/Wrist/Hand (R / L)
___ Mid Back (R / L)
___ Low Back (R / L)
___ SI Joint (R / L)
___ Hips (R / L)
___ Sciatica (R / L)
___ Legs (R / L)
___ Knees/Ankles/Feet (R / L)
___ Other: _____

Adult Case History

_____ Stress : scale 1-10
_____ Bowel Movement: /wk
_____ Water: oz / day
_____ Juice: glasses/day

_____ Coffee: cups / day
_____ Soda: oz /day
_____ Alcohol: glasses /wk
_____ Tobacco: /day

_____ Soy Use: _____
_____ Artificial Sweetener Use:
___ Equal (Aspartame)
___ Splenda (Sucralose)

_____ Cardio: x/wk
_____ Weight Train: x/wk
_____ Yoga / Pilates: x/wk
_____ Sports: hrs/wk

Rank any symptoms you are currently having 1 - 10 or check applicable boxes.

EARS
___ Noise (Ring/Hiss/Pound)
___ Plugged
___ Popping
___ Ache / Infection
___ Draining
___ Itchy
___ Hearing Loss
___ Dizziness/Vertigo
___ Excessive Ear Wax
___ Other: _____

EYES
___ Burn / Tear / Itchy
___ Ache / Dry / Red
___ Crust in am / Film
___ Bouts of Blurriness
___ Floaters / Spots
___ Tired / Puffy
___ Stye
___ Twitching around eye
___ Dark circles
___ Light sensitive
___ Other: _____

SINUS
___ Nosebleeds
___ Dry
___ Drain
___ Stuffy/plugged
___ Sneeze frequently
___ Taste / Smell loss
___ Post nasal drip

SKIN / HAIR / NAILS
___ Skin Rash: _____
___ Acne: _____
___ Butt Acne
___ Dry skin
___ Eczema / Psoriasis
___ Nails (white spots/ridges)
___ Nails (weak/ peeling)
___ Hair loss
___ Limp Hair
___ Varicose / Spider veins
___ Damp hands / feet
___ Dandruff
___ Red dots
___ Bruise easily
___ Bumps on Back of Arms
___ Missing outer 1/3 of eyebrow
___ Cold hands / feet
___ Ingrown toenails
___ Other: _____

STOMACH
___ Heartburn
___ Indigestion
___ Stomach Ache / Cramps
___ Nausea/Vomiting
___ Bloat After Eat
___ Gas / Flatulence
___ Belching
___ Ulcer
___ Other: _____

BOWELS
___ Diarrhea
___ Constipation
___ Incomplete
___ Bulky
___ Cramps in Abdomen
___ Pain w/ Bowel Movement
___ Laxative / Suppository Use
___ Colonics / Enemas
___ Anal Itching
___ Hemorrhoids:
___ Swollen / Achy
___ Burning / Itchy
___ Blood
___ Other: _____

STOOL CONSISTENCY
☐ Normal
___ Light colored feces
___ Soft
___ Fluffy
___ Hard
___ Pebbles
___ Ribbon-like
___ Mucous
___ Contain string-like
___ Black / White specks
___ Contain undigested food

APPETITE / DIET
☐ Low ☐ Norm ☐ High appetite
___ Crave Starch / Sweets
___ Crave Salt
___ Crave Chocolate / Ice Cream
___ Eat lots of spicy foods
☐ Nighttime snack: _____
If meals are missed:
___ Nausea
___ Extreme hunger
___ Cold / Clammy
___ Rapid heartbeat
___ Irritability
___ Light headed

LIBIDO / SEXUALITY
☐ Low ☐ Normal ☐ High
Orgasm:
☐ none ☐ poor ☐ good ☐ great

CHEST
___ Tension / Tight
___ Pressure / Heaviness
___ Congestion
___ Chest / Sternal Pain
___ Palpitations-Heart Skip
___ Heart Racing / Slowing
___ Other: _____

RESPIRATORY
___ Short of breath - Constant
___ Short of breath - Exertion
___ Wheeze
___ Air hunger / yawn
___ Frequent Sighs
___ Upper Resp Infx
___ Asthma
___ Other: _____

SLEEP
Quality of Sleep:
☐ Poor ☐ Fair ☐ Good ☐ Great
Hours in bed _____
Hours asleep _____
Interrupted ____ x per night
Waking at ____ am
___ Difficulty falling asleep
___ Difficulty staying asleep
___ Crave sleep during day
___ Awaken Suddenly (Jolt)
___ Don't dream
___ Nightmares / Epic dreams
___ Night sweats
___ Restlessness
___ Restless Leg Syndrome

EMOTIONS
___ Sadness / Depression
___ Moodiness / Irritable
___ Frustrated / Angry
___ Nervous / Anxiety
___ Grief
___ Panic / Fear
___ Cry
___ S.A.D.
___ OCD
___ Other: _____

HEADACHES
___ Base of Skull (back)
___ Side of Head (temples)
___ Frontal (above eyes)
___ Top of Head
___ Entire Head
___ Migraines

COGNITION
___ Forget Names
___ Forget Numbers
___ Forget Words
___ Forget Actions
___ Difficulty Concentrating
___ Other: _____

ENERGY
☐ Normal ☐ Low ☐ Variable ☐ High
___ Slow to start in am
___ Low energy after meals
___ Energy crash at ___ am/pm
___ Other: _____

URINATION
Times during the night _____
___ Urgency
___ Burning/Pain
___ Odor/Foamy
___ Dark color
___ Incontinence
___ Urinary tract infection
___ Kidney troubles
___ Other: _____

MALE ONLY
___ Erectile Dysfunction
___ Prostate Problems
____ Burn
____ Achy / Pain
____ Restriction / Swelling
___ Other: _____

FEMALE ONLY:
Date Last Period: _____
Cycle Length (28-30 days): _____
Days of Flow _____
Cramps: ☐ mild ☐ mod ☐ severe
PMS: ☐ mild ☐ mod ☐ severe
___ Vaginal Itching / Discharge
___ Heavy flow
___ Large clots
___ Yeast Infection
___ Menopause
___ Hot Flashes
___ Vaginal Drynes
___ Painful Intercourse
___ Other: _____

OTHER HEALTH EVENTS/ ISSUES: