Kym Caporale, DOM
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Dear Patient:

Thank you for your visit today. In order to provide you with holistic care and address the root cause of your health concerns, we would like you to complete a detailed and comprehensive health questionnaire. Your answers will help you achieve better treatment results. The more you are willing to share with us, the better we can treat the root cause of your health conditions and symptoms.

Patient's Name: _____ Date:_____

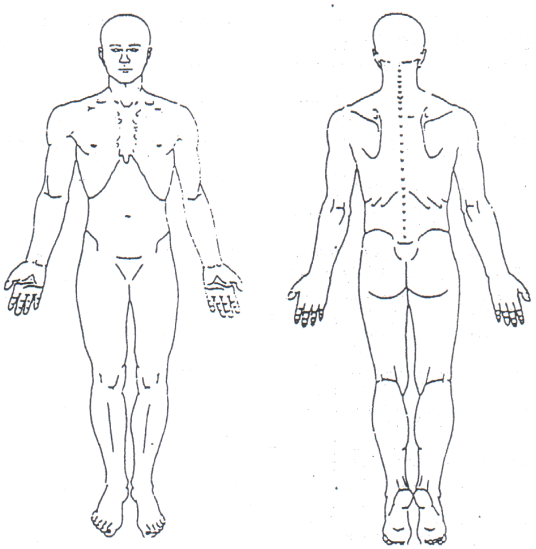
Doctor's Name _____ Referred By _____ Date _____ File #:

PATIENT HEALTH HISTORY **Re-evaluation:** [ ]Yes

1. Name: _____ Gender: [ ]M, [ ]F Age: _____ Height: _____ Weight: _____
   Address: _____ City _____ State _____ Zip _____
   Cell Phone: _____ Home Phone _____ Birth Date _____
   Email _____
   *Wei Institute Doctor's Name: _____ Phone: _____Fax:_____
   *Wei Institute Doctor's Name Email: _____
   * Required information – without it your treatment recommendation will be delayed or not processed
2. Have you ever used: [ ]Chiropractic Treatment [ ]Chinese Herbal Medicine [ ]Acupuncture [ ]Homeopathy
   If yes, for which conditions? _____
   If no, would you like to hear about options for your condition (please circle)? Yes No
3. What is the reason for your visit? What is your chief complaint? (Describe your condition at its worst)
   _____
   _____
   Other Complaints: _____
   Diagnosed Medical Conditions: _____
4. Cause of Health Conditions: [ ] Injury [ ] Auto Accident [ ] Personal Injury [ ] Other: _____
   Has the accident been reported? Yes No Reported to: [ ]Employer [ ]Auto Carrier [ ]Other: _____
   Are you now or have you ever been disabled? Yes No Date: _____ Cause:_____
   Have you ever retained an attorney? Yes No Name: _____ Phone: _____
5. Pain Symptoms: a._____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____
   (In Order b._____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____
   of Severity) c._____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____
6. Please circle areas of pain or discomfort and mark them using the codes listed below:
   N=Numbness, T=Tingling, B=Burning, P=Pain, S=Soreness, A=Ache, SB=Stabbing, SF=Stiffness, X=Scars

   List the frequency and severity of your condition on a scale of 1 to 5:

Frequency:	Severity:
1=20% of the time	1=Annoying
2=40% of the time	2=Impairment to Activity
3=60% of the time	3=Need Medication
4=80% of the time	4=Impairment with Medication
5=100% of the time	5=Severe (Need Hospitalization)



Location	Frequency	Severity	Initial Cause	Getting Worse?
a. _____	_____	_____	_____	Yes No
b. _____	_____	_____	_____	Yes No
c. _____	_____	_____	_____	Yes No

   Does it affect other areas of your body (please circle)? Yes No
   If yes, explain: _____
7. Do you have, or have you ever had:

Osteoarthritis ___	Bone Spurs ___	Non-union Fracture __	
Bulging Disc ___	Tendonitis___	Avascular Necrosis ___	Cartilage injury ___
Herniated Disc ___	Joint Separations ___	Post-herpetic neuralgia ___	(Meniscus Tear, Chondromalacia
DDD ___	Bursitis ___	Intercostal Neuralgia ___	Patellar Syndrome)
Stenosis ___	Sprains ___	Morton's Neuroma ___	

8. Does the condition interfere with (please circle): Work Sleep Other: _____
   Please describe: _____
   Without treatment, how would it affect your quality of life? _____
   _____

9. What seems to make the condition better? _____
What seems to make it worse? _____
What treatments have you tried? _____

10. If you are currently under the care of a health care practitioner for any conditions or injuries, please provide their:
Name: _____ Phone: _____ Email: _____
Description of Treatment: _____

11. Please list any current therapies: _____

12. Please describe your lifestyle (please circle):

Appetite: Low Moderate High

Thirst for Water: Yes No _____ Glasses/Day

Coffee: Yes No _____ Cups/Day

Soda: Yes No _____ Cups/Day

Artificial Sweeteners: Yes No

Cravings for Sugar: Yes No

Cravings for Salty Foods: Yes No

Stress Level: High Moderate Low

Alcohol: Yes No _____ Glasses/Day

Smoking: Yes No _____ Cigarettes/Day

Marijuana: Yes No _____ Times/Day

Other Drugs : _____

Occupational Hazards: _____

Exercise (please circle):

None Very Active

Light Elite Athlete

Moderate

Active

Type of Exercise: _____

Frequency of Exercise: _____

13. List vitamins or supplements taken in the last 2 months: _____

14. List prescribed and over-the-counter pharmaceutical medication taken in the last 2 months:
Anti-acids (please check): [ ] TUMS [ ] Zantac [ ] Other: _____
Proton Pump Inhibitors (please check): [ ] Prilosec [ ] Pepcid [ ] Prevacid [ ] Other: _____
Other Medications: _____
_____

15. Please describe your health history (please check).

Now	Past		Now	Past		Now	Past		Now	Past	
___	___	Acid Reflux/Heart Burn	___	___	Coronary artery disease	___	___	High Cholesterol	___	___	Rheumatic Fever
___	___	AIDS/HIV	___	___	Cystic Fibrosis	___	___	Hyperlipidemia	___	___	Rheumatoid Arthritis
___	___	Alcoholism	___	___	Diabetes	___	___	Influenza	___	___	Sarcoidosis
___	___	Allergies	___	___	Diverticulitis	___	___	IBD	___	___	Scoliosis
___	___	Anemia	___	___	Drug Withdrawal	___	___	IBS	___	___	Scarlet Fever
___	___	Appendicitis	___	___	Emphysema	___	___	Kidney Stones	___	___	Small intestinal bacterial overgrowth (SIBO)
___	___	Arthritis	___	___	Epilepsy	___	___	Kidney Failure			
___	___	Arteriosclerosis	___	___	Eczema	___	___	Lyme Disease	___	___	Seizures
___	___	Asthma	___	___	Erectile Dysfunction	___	___	Meniere's Disease	___	___	Stroke
___	___	Atrial Fibrillation	___	___	Fatty Liver	___	___	Mental Disorder	___	___	Thyroid Disorders
___	___	Birth Trauma	___	___	Fibromyalgia	___	___	Migraines	___	___	Tuberculosis
___	___	Bronchiectasis	___	___	Fibroid	___	___	Multiple Sclerosis	___	___	Typhoid Fever
___	___	Breast Lump	___	___	Gall Bladder Stones	___	___	Ovarian Cyst	___	___	Ulcers, Location: _____
___	___	Cancer	___	___	Goiter	___	___	Pacemaker	___	___	Ulcerative Colitis
___	___	Candida	___	___	Gout	___	___	Pancreatitis	___	___	Crohn's Disease
___	___	Chicken Pox	___	___	Hernia (Hiatal)	___	___	Pleurisy	___	___	UTI
___	___	Chronic Bronchitis	___	___	Hernia (Inguinal)	___	___	Pneumonia	___	___	Interstitial Cystitis
___	___	Chronic kidney disease	___	___	Heart Murmur	___	___	Prostatitis	___	___	Vitiligo
___	___	Cirrhosis	___	___	Hepatitis	___	___	Psoriatic arthritis	___	___	Venereal Disease
___	___	Congestive heart failure	___	___	Herpes	___	___	Psoriasis	___	___	Whooping Cough
___	___	COPD	___	___	High Blood Pressure	___	___	Pulmonary fibrosis	___	___	Other, Describe _____

16. Please use the point scales to rate your symptoms over the past 3 months.
1 = Occasional, Not Severe 2 = Occasional, Severe 3 = Frequent, Not Severe 4 = Frequent, Severe

Digestive Tract			
___Acid reflux/Heart burn	___Bloating	___Gluten Intolerance	___Difficulty Swallowing
___Poor Digestion	___Gas	___Food Allergies	___Diarrhea
___Nausea & Vomiting	___Hiccups	___Chemical Sensitivities	___Constipation
	___Bad Breath	___Malnutrition	___Laxative Use

___Blood in Stool
___Mucous in Stool
___Black Stool
___Stomach Pains/Cramps
___Abdominal Pain
___Abdominal Spasms
___Lack of Bowel Control
___Itchy Anus
___Rectal Pain
___Hemorrhoids
___Anal Fissures
Bowel Movements:
Frequency_____
Color_____
Texture/Form_____
Odor_____

General
___Sweat Easily
___Night Sweats
___Gall Bladder Trouble
___Cold Hands or Feet
___Poor Circulation
___Spitting Blood
___Fever
___Chills
___Muscle Cramps
___Lower Extremity Edema
___Vertigo or Dizziness
___Bleed or Bruise Easily
___Frequent Illness
___Seasonal Allergy
___Addicted to Drugs
___Addicted to Smoking
___Peculiar Taste:
Describe: _____

Respiratory
___Tight Chest
___Shortness of Breath
___Difficulty Breathing
When Lying Down
___Itching Inside the Chest
___Wheezing
___Persistent Cough
___Coughing Blood
___Cough: Wet / Dry, Thick / Thin
Color of Phlegm_____
___Other Lung Problems

Urinary
___Bedwetting
___Blood in Urine
___Lack of Bladder Control
___Pain During Urination
___Frequent/urgent urination
___Incomplete Urination
___Wake to Urinate
___Prostate Problem
___Genital Itch or Discharge
___Premature Ejaculation
___Recurrent Bladder Infections
___Impotence
___Increased Libido
___Decreased Libido

Weight & Eating
___Recent Weight Loss
___Recent Weight Gain
___Binge Eating/Drinking
___Craving Certain Foods
Describe: _____
___Excessive Weight
___Loss of Taste
___Compulsive Eating
___Poor Appetite
___Heavy Appetite
___Strongly Like Cold Drinks
___Strongly Like Hot Drinks
___Water Retention

Musculoskeletal
___Muscle Pains
___Muscle Cramps
___Pains or Aches in Joints
___Stiffness/Limited Range of Motion
___Pains or Aches in Muscles
___Feeling of Weakness/Tiredness
___Swollen Tender Joints
___Pain in Legs
___Hip Tightness/Coldness/Pain
___Rib Pain
___Neck/Shoulder Pain
___Upper Back Pain
___Back Pain
___Lower Back Pain
___Sciatic Pain

Cardiovascular
___Heart Murmur
___Heart Palpitations
___Irregular or Skipping Heartbeat
___Rapid or Pounding Heartbeat
___Chest Pain
___Difficulty Breathing
___High Blood Pressure
___Low Blood Pressure
___Blood Clots
___Anemia
___Fainting
___Tachycardia

Emotions
___Mood Swings
___Anxious, Fear, Nervous
___Angry Irritable, Aggressive
___Easily Stressed
___Argumentative
___Frustrated, Cries Easily
___Depression
___Abuse Survivor
___Considered/Attempted Suicide
___Seeing a Therapist
___Obsessive Behavior
___Compulsive Thoughts
___Uncontrollable Urges

Mind
___Poor Memory
___Difficulty Completing Projects
___Difficulty with Mathematics
___Underachiever
___Poor/Short Attention Span
___Confusion
___Easily Distracted
___Difficulty Making Decisions
___Learning Disability

Neurological
___Seizures
___Numbness
___Tics
___Foot Neuropathy

Energy & Activity
___Apathy, Lethargy
___Attention Deficit
___Fatigue
___Lack of Strength
___Body Heaviness
___Hyperactivity
___Restlessness
___Shortness of Breath
___Stuttering or Stammering
___Slurred Speech

Ears
___Itchy Ears
___Ear Aches, Ear Infections
___Drainage from Ears
___Hearing Loss
___Reddening of the Ears
___Ringing in the Ears
___Headaches
___Concussions

Nose
___Stuffy Nose
___Dryness Inside the Nose
___Chronically Red,
Inflamed Nose
___Sinus Problem
___Hay Fever
___Sneezing Attacks
___Excessive Mucous Formation
___Back Dripping
___Nose Bleeding

Eyes
___Glasses/Contacts
___Watery or Itchy Eyes
___Red, Swollen or Sticky Eyelids
___Bags/Dark Circles Under Eyes
___Poor Vision
___Blurred or Tunnel Vision
___Sensitive to Sunlight
___Eye Strain
___Eye Pain
___Red Eyes
___Itchy Eyes
___Easily Fatigued Eyes
___Spots in Eyes
___Night Blindness
___Glaucoma
___Cataract

Head
___Headaches
___Migraines
___Faintness
___Dizziness
___Facial Flushing
___Facial Pain
___TMJ

Sleep
___Insomnia
___Sleep Disorder
___Difficulty Falling Asleep
___Difficulty Staying Asleep
___Wakes Up Frequently
___Morning Shakiness
___Cannot Wake Up in Morning

Mouth & Throat
___Chronic Coughing
___Gagging, Often Clearing Throat
___Sore Throat, Hoarse, Voice Loss
___Swollen/Discolored Tongue/Lips
___Sores on Lips or Tongue
___Canker Sores
___Itching on Roof of Mouth
___Dry Mouth
___Excessive Saliva
___Recurrent Sore Throat
___Excessive Phlegm
Color: _____
___Swollen Glands
___Lumps in Throat
___Enlarged Thyroid
___Teeth Problem
___Gum Problem
___Grinding Teeth

Skin & Hair
___Acne
___Itching
___Hives
___Rash
___Eczema
___Dry Skin
___Ulcerations
___Hair Loss
___Dandruff
___Flushing or Hot Flashes
___Change in Hair/Skin Texture
___Loss in Pigmentation
___Skin Fungal Infections

For Women Only
Age Menstrual Cycle Began:
_____
Length of Cycle (Day 1 - Day 1):
_____
Duration of Flow: _____
___Dark Color Flow
___Clots in Flow
___Excessive Flow
___Irregular Cycle
___Painful Period
___Painful Intercourse
___Excessive Vaginal Discharge
___Menopause Symptoms
___Lump in Breast
___Vaginal Dryness
___Vaginal Sores
___Vaginal Odor
Vaginal Discharge Color:
_____
# of Pregnancies: _____
# of Live Births: _____
# of Premature Births: ____
Age at Menopause: _____
Date Last Period Began:
_____

Any Other Symptoms:

_____
_____

17. Operations and Procedures

Date		**Date**		**Date**		
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus	**Other:** _____
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia	**Date:** _____
_____	Gall Bladder	_____	Gynecological	_____	Thyroid	
_____	Back Operation	_____	Rectal Surgery	_____	Stomach	

List and date any accidents or falls (please check):
[ ] Car _____, [ ] Recreation _____, [ ] Sports _____, [ ] School _____, [ ] Other _____
List any broken bones: _____
Have you ever had spinal taps or spinal injections (please circle)? Yes No Date: _____
Have you ever lost consciousness (please circle)? Yes No Why? _____
Have you ever had X-ray taken? Yes No Date: _____ By Whom? _____
For what ailment were these X-rays taken? _____
Do you suffer from any condition other than that for which you are now consulting us? _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The heath care provider's office will prepare necessary paperwork to assist me in the filling insurance claims but cannot guarantee reimbursement. Direct payments made from the insurance company to the health care provider's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payments for these services to the health care provider's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collections of the account.
I authorize the health care provider to examine and treat my condition as deemed appropriate through the use of chiropractic care, acupuncture, Traditional Chinese Medicine, and/or other natural healing methods.

Patient's / Guardian's Signature: _____ Date: _____