ADVANCED WELLNESS CENTER
714.709.8030 • 14340 Bolsa Chica Road • Westminster, CA 92683

New Patient Questionnaire

Welcome to the **Advanced Wellness Center**. *Our approach requires us to have a thorough understanding of your health history to determine underlying causes affecting your health. Please take your time to complete this form – carefully and thoroughly. The more detailed and accurate you are, the more we will be able to help you achieve your health goals.*

Name _____ Date _____

Height _____ Weight _____ Date of birth _____ Age _____

❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Partnered ❑ Children (ages) _____

Address _____ City _____ Zip _____

Home phone _____ Bus. phone _____ Mobile _____

Email _____ ❑ Please **do not** add me to your newsletter list
(The newsletter is a source of complementary health news. We will not sell or share your info with any third party and will not SPAM your inbox with frequent messages.)

How did you find us? _____ Referred by _____

Is your physician aware you're seeking treatment at AWC? ❑ yes ❑ no May we contact? ❑ yes ❑ no

Physician's name _____ Phone _____ City _____

Occupation and work activities _____

Hobbies and sports _____

Do(es) your injury/injuries limit your activites? ❑ yes ❑ no

How? _____

Questions

What are the symptoms or problem that you want us to help you with? List the very first time that you noticed the condition and describe carefully anything that you suspect may have played a role in its development. *(Please use back of last page for more space.)*

Why did you come to our Center? (The urging or concern of your friends or family successfully treated here; you have heard about the results we have had with conditions like yours; another doctor referred you; or you are looking for some understanding why you're experiencing pain or symptoms and how to regain your health.)

Print this page and circle those you presently (in recent weeks) have. Underline those you have had in the past.

General
Headache
Fever
Chills
Sweats
Fainting
Dizziness
Imbalance
Seizures
Epilepsy
Sleeping difficulties
Sleep apnea
Quality of sleep
Sleep ___hrs/night
Feel run-down
Fatigue
Hypoglycemia
Nervousness/anxiety
Panic attacks/phobias
Depression
Mental disorder
Alcohol problems
Drug problems
Diabetes
Neuralgia
Anemia
Cancer
Memory loss
Scarlet fever
Typhoid fever
Rheumatic fever
Measles
Mumps
Chicken pox
Weight loss ___lbs
Weight gain ___lbs
Other _____

Ear, Nose & Throat
Eye strain/pain
Failing vision
Blurred vision
Glaucoma
Sensitivity to light
Hearing problems
Ear noises
Ear discharge
Sinus infection
Nose bleeds
Nasal obstruction
Nasal drainage
Post nasal drip
Sore throat
Hoarseness
Loss of voice
Dental decay
Mouth sores
Gum disease
Teeth grinding
Jaw pain
Frequent colds
Thyroid condition
Tonsillitis
Enlarged glands
Hay fever
Other _____

Skin
Rashes
Skin eruptions
Eczema
Itching
Bruise easily
Dry skin
Boils
Moles
Varicose veins
Sensitive skin
Hair loss
Other _____

Respiratory
Asthma
Pneumonia
Emphysema
Tuberculosis
Bronchitis
Pleurisy
Chronic cough
Spitting phlegm
Spitting blood
Chest pain
Difficult breathing
Shortness of breath
Other _____

Cardiovascular
Rapid heartbeat
Slow heartbeat
Irregular heartbeat
High blood pressure
Blood clots
Low blood pressure
Pain over heart
Pacemaker
Hardening of arteries
Swelling of ankles
Poor circulation
Stroke/TIA
Other _____

Muscle & Joint
Stiff neck
Backache
Gout
Swollen joints
Painful joints
Arthritis
Bursitis
Tendinitis
Muscle or joint weakness
Muscle spasms or cramps
Fibromyalgia
Foot trouble
Spinal curvature
Osteoporosis
Other _____

Genitourinary
Frequent urination
Night urination __ times
Painful urination
Blood in urine
Pus in urine
Kidney infection or stones
Bed-wetting
Inability to control urine
Prostate trouble
Hernia
Sexually transmitted disease
Sexual dysfunction/difficulty
Other _____

Gastrointestinal
Trouble swallowing
Bad breath
Indigestion/heartburn
Nausea
Poor appetite
Belching or passing gas
Excessive hunger
Cravings
Eating disorder
Vomiting of blood
Pain over stomach
Ulcers
Distention of abdomen
Constipation
Diarrhea
Colitis
Appendicitis
Bowel condition
What aggravates the above?
_____
Hemorrhoids (piles)
Intestinal worms
Parasites
Hepatitis
Liver trouble
Gall bladder trouble
Jaundice
Bad body odor
Other _____

For Women Only
PMS (list symptoms)
_____
Mood swings/irritability
Painful menstrual period
Excessive flow
Bleeding between cycles
Irregular cycle
Cramps or backache w/period
Endometriosis
Ovarian cysts
Uterine fibroids
Abnormal PAP results
Vaginal discharge
Breast pain/tenderness
Breast lumps
Menopausal symptoms
Hot flashes
Other _____

List surgical procedures or hospitalizations with dates: _____

_____

Accidents, with or without injury (car accidents, slips, falls...): _____

Broken bones or dislocations: _____

X-ray, MRI, CAT or bone scans (where, when and what was found?): _____

_____

Medical History

Please indicate whether there is a **history of the following conditions in your family**: heart disease, high blood pressure or circulatory conditions, cancer, diabetes, osteoarthritis, ankylosing spondylitis, rheumatoid arthritis, multiple sclerosis, muscular dystrophy, mental illness, auto-immune disorders, asthma, allergies, psoriasis, eczema, alcoholism, drug abuse or any other conditions that are pertinent to your present state of health.

Were you breastfed? ❑ yes ❑ no

Did you require any medical attention, hospitalization, surgery or medication as a child?

Before age 2: ❑ yes ❑ no Age 2 to 10: ❑ yes ❑ no Please explain any "yes" answers.

Have you had any recurring infections or inflammations? ❑ yes ❑ no

(i.e. tonsillitis, bladder or ear infections, vaginitis, colitis, sinusitis, yeast overgrowth, etc.) Please explain fully.

What do you feel your weakest organ system is and why? (i.e. heart, kidney, lungs etc.)

How many times each year do you have a cold, sinusitis, the flu, sore throat or bronchitis? ❑ 1 ❑ 2 ❑ 3 ❑ 4+

What is the severity and how long do the symptoms last? _____

Your Current Physical Health

On a scale of 0-10 (10 best), what number do you believe reflects your current level of health? _____

Is your health currently getting ❑ better ❑ worse ❑ staying the same?

On a scale of 0-10 (10 most energetic), how would you rate your energy level? _____

What time of day is it lowest? _____ What time of day is it highest? _____

What are the most significant steps which you have taken to-date to improve your health?

Have you had chiropractic care or acupuncture before? ❑ acupuncture ❑ chiropractic ❑ both ❑ neither

List name(s) and when seen: _____

Please explain the results:

What other healthcare professionals do you see on a regular basis? (physician, dentist, nutritionist, gynecologist...)

Please list any and all drugs/medications (over-the-counter or prescription), which you are presently taking or have taken. When did you start/stop their use? Dosage?

What supplements, vitamins and/or herbs do you take? How did you determine need and dosage for each one?

For those that apply to you, please list indicated quantities consumed:
Smoke cigarettes (number per day) _____ Other tobacco (amount per day) _____
Exposed to second-hand smoke, pollution or chemicals at work or during hobbies? _____
Wine/Beer (glasses per day or week) _____ Hard liquor (ounces per day or week) _____
Coffee (6oz cups per day) _____ Tea (6oz cups per day) _____
Soda (cans per day) ____ caffeinated ____ non-caffeinated ____ diet
Chocolate/other sweets (ounces per day/week) _____
Water (glasses per day) ____ chlorinated ____ bottled ____ filtered

What allergies to foods, drugs or inhalants do you have and how do you react?

Typically, how often do you exercise per week? ❑ never ❑ once or twice ❑ every other day ❑ daily
What exercises are part of your typical routine?

What do you typically eat for:

Breakfast _____ Time _____

Lunch _____ Time _____

Dinner _____ Time _____

Snacks _____ Time _____

Drink (with or between meals) _____

How many times a day/week do you have bowel movements: _____ ❑ day ❑ week

Are your bowel movements: ❑ loose ❑ hard ❑ difficult to pass ❑ strong-smelling ❑ accompanied by gas

What is the typical color: ❑ blackish ❑ brown ❑ clay ❑ greenish ❑ bloody

Your Current Mental Health

On a scale of 0-10 (10 highest), what number do you believe reflects your current level of stress? _____
Please list the three most significant stressful events in your life. Indicate those continuing to impact your life.

Have you consulted a doctor, counselor, psychologist or therapist for the aforementioned condition? ❑ yes ❑ no

Did it help? ❑ yes ❑ no How? _____

Initial _____

Your Pain

Is your health problem a work-related injury? ❑ yes ❑ no If "yes" did you report the injury? ❑ yes ❑ no

In what position do you sleep? ❑ side ❑ back ❑ front Do you use a pillow? ❑ yes ❑ no

Did your pain or symptoms come on: ❑ gradually ❑ suddenly Is it: ❑ constant ❑ intermittent

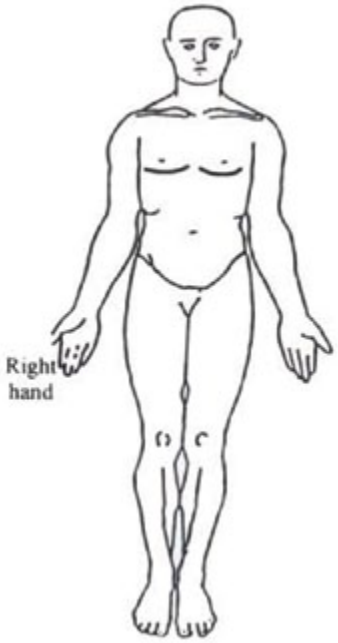
What time of the day is the pain the worst: ❑ morning ❑ afternoon ❑ evening ❑ night ❑ constantly

What makes your pain or symptoms worse?

What makes your pain or symptoms better?

Patient Pain Drawing

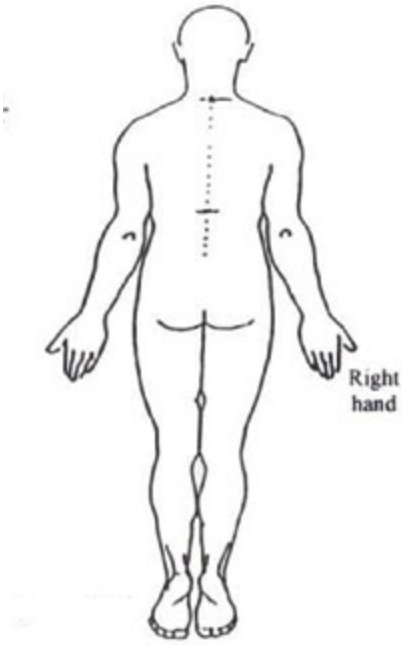
Please place the symbol(s) on the body in the area(s) that best describe(s) the pain or discomfort you are having:



PP = Sharp Pain
DD = Dull Pain
BB = Burning
NN = Numbness
TT = Tingling
SS = Stabbing
AA = Ache
Th = Throbbing

On a scale of 0 - 10
(0 = pain free, 10 = constant disabling pain),
rate each area of pain:

Neck _____
Mid back _____
Low back _____
Shooting pain _____
Numbness _____
Other _____



In which of the following areas would you like our support? (Check all that apply, circle the one that's most important.)

❑ Have more energy/vitality
❑ Be happier
❑ Monitor my body's aging
❑ Be less tired after lunch
❑ Not need so many drugs
❑ Be stronger
❑ Get rid of allergies
❑ Think more clearly
❑ Be more flexible
❑ Reduce my risk of degenerative disease
❑ Improve my skin quality/youthfulness
❑ Slow accelerated aging
❑ Sleep better
❑ Be less depressed
❑ Maintain a healthier life longer
❑ Get less colds and flu
❑ Be less moody
❑ Reduce body fat
❑ Have more sex drive
❑ Improve my memory
❑ Learn how to reduce stress

Initial _____

Additional Comments

This questionnaire is strictly confidential between you and the AWC health professional. Your accurate responses are vital to effective healthcare at this office. Please go back over your responses and consider their accuracy. *Thank you!*

I authorize the Advanced Wellness Center's doctors and staff to perform examinations and treatment deemed necessary by my provider for my condition.

Signature _____ Date _____

Guardian's signature _____ Date _____