HealthTouch Chiropractic
11481 SW Hall Blvd, suite 101 Tigard, OR 97223
503-941-9912 fax 503-941-9915
Chiropractic Holistic & Wellness Care Rehab & Physical Therapy Massage Therapy Nutrition
www.HealthTouch.Info

HEALTH Profile

(patient to complete)

Name: _____ **Date:** _____

Best Phone # _____ Best time to Call: _____

Email: _____

Basic Patient Information:

☐ Male ☐ Female Height: _____ Weight: _____ Date of Birth: _____

Weight loss Goals:

How much weight would you like to lose? _____ lbs

Why do you want to lose weight? (3 reasons)

1._____

2._____

3._____

Background:

Have you tried other diets? Y N

How did you do? _____

What do you find most difficult when losing weight?_____

Is your family aware that you are starting this program? Y N

Can you count on them to be helpful and supportive? Y N

Do you have supportive friends and/or co-workers? Y N

Do you know of anyone who might want to start this program with you? _____

Can you eat every 3 hours? Y N

On a scale of 1-10, how motivated are you to succeed? (10=very motivated) _____

Overall Health:

On a scale of 1-10, how healthy do you feel? (10 = very healthy) _____

How many hours per day do you work? _____

On a scale of 1-10, how would you rate your stress level? _____

How many hours of sleep do you get per night? _____

Daily Physical Activity Level: ☐ Low ☐ Moderate ☐ High

Health Review & Information

HEALTH QUESTIONS:

Allergies:

Food Allergies: ☐ None ☐ Soy ☐ Other: _____

Medication Allergies: ☐ None

☐ Yes - list: _____

Medications: Please list any medications that you are taking: *include Name & Dosage*

☐ Blood Thinners: _____

☐ Blood Sugar Lowering meds (ie: insulin, oral hypoglycermics): _____

☐ Diuretics (water pills): _____

☐ Lithium: _____

☐ Steroids: _____

☐ Other: _____

_____

_____

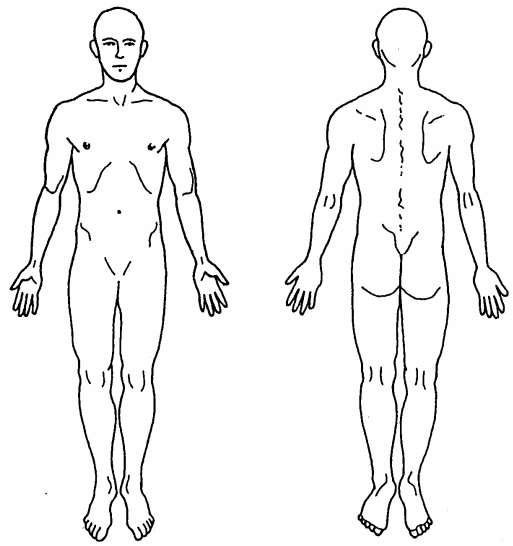
Doctors: Please list any physicians you see and their specialty

Specialty	*Name*	*Location*	*Phone (if known)*
Primary Care			

Symptoms: **Mark and describe any areas of pain.**

If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels.

Stiff
Soreness
Ache
Burning
Numbness
Pins & Needles
Stabbing
Throbbing



HEALTH ISSUES:

Diabetes - Do you have diabetes? Y N ***(if no, skip to next section)***

When were you diagnosed? _____

Are you under the care of a physician for this condition? Y N

Which type of diabetes? (please mark)

- ☐ Type 1: insulin dependent *(insulin injections only)*
- ☐ Type 2: non-insulin dependent *(diabetic pills)*
- ☐ Type 2: insulin dependent *(diabetic pills AND insulin)*

Is your blood sugar monitored? Y N

If so, by whom? □ Myself □ Physician □ Other: specify _____

Are you taking any medication for this condition? Y N

If so, please list it: _____

Do you tend to be hypoglycemic? Y N

Digestive health / stomach - **Please mark those that currently apply to you:** ***(if none, skip to next section)***

- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Heartburn
- ☐ Gastric Ulcer
- ☐ Other: _____

Are you under the care of a physician for this condition? Y N

Are you taking any medication for this condition? Y N

If so, please list it: _____

Intestinal health / Colon Health **- Please mark the issues that currently apply to you:** ***(if none, skip to next section)***

- ☐ Constipation
- ☐ Diarrhea
- ☐ Irritable bowel syndrome
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Diverticulosis
- ☐ Other: _____

Are you under the care of a physician for this condition? Y N

Are you taking any medication for this condition? Y N

If so, please list it: _____

HEALTH ISSUES - continued:

Heart health **- Have you had a cardiovascular event? Y N** ***(if no, skip to next section)***

If so, please specify: _____

How long ago? _____

Are you under the care of a physician for this condition? Y N

Are you taking any medication for this condition? Y N

If so, please list it: _____

Do you have a history of arrhythmia (irregular heartbeat)? Y N

High Blood Pressure **- Do you have high blood pressure? Y N** ***(if no, skip to next section)***

If so, do you have your blood pressure checked? Y N By whom? _____

Are you under the care of a physician for this condition? Y N

Are you taking any medication for this condition? Y N

If so, please list it: _____

What is your approximate average blood pressure? _____

Inflammatory Conditions **- Please mark the situations that apply to you:** ***(if none, skip to next section)***

- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Psoriasis
- ☐ Rheumatoid Arthritis
- ☐ Other autoimmune/inflammatory condition: _____

Are you under the care of a physician for this condition? Y N

Are you taking any medication for this condition? Y N

If so, please list it: _____

Kidney health **- Have you been diagnosed with kidney disease or on dialysis? Y N** ***(if no, skip to next section)***

Are you under the care of a physician for this condition? Y N

Are you taking any medication for this condition? Y N

If so, please list it: _____

Have you ever had Gout? Y N

Liver health **- Do you have liver problems? Y N** ***(if no, skip to next section)***

If so, please specify: _____

Are you under the care of a physician for this condition? Y N

Are you taking any medication for this condition? Y N

If so, please list it: _____

HEALTH ISSUES - continued:

Reproductive - Female systems ***(if male, skip to next section)***

Please mark the situations that currently apply to you:

- ☐ Irregular Periods
- ☐ Heavy Periods
- ☐ Painful Periods
- ☐ Menopause
- ☐ Amennorhea (no period, not menopause)
- ☐ Hysterectomy
- ☐ Fibrocystic: breasts / ovaries
- ☐ Uterine fibroma
- ☐ Cancer: uterus, breast

Are you under the care of a physician for this/these condition(s)? Y N

Are you taking any medication for this/these condition(s)? Y N

If so, please list it: _____

Please indicate the date of your last menstrual cycle: _____

Are you pregnant? Y N

Are you breastfeeding? Y N

Thyroid Function **- Do you have thyroid problems? Y N** ***(if no, skip to next section)***

Are you under the care of a physician for this condition? Y N

Are you taking any medication for this condition? Y N

If so, please list it: _____

Emotional Evaluation **- Please mark the situations that apply to you:** ***(if none, skip to next section)***

- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks
- ☐ Anorexia (or history of)
- ☐ Bulimia (or history of)

Are you under the care of a physician for this condition? Y N

Are you taking any medication for this condition? Y N

If so, please list it: _____

HEALTH ISSUES - continued:

In General

Do you have cancer? Y N

Are you in cancer remission? Y N

(if you answered no to both questions, skip to "A" below)

If so, please specify type and indicate when it was and for how long:

_____

Are you under the care of a physician for this condition? Y N

Are you taking any medication for this condition? Y N

If so, please list it: _____

(A)

Are you generally fatigued or have low energy? Y N

Do you get cold easily? Y N

Do you have cold hands and/or feet? Y N

Do you have other health problems? Y N ***(if no, skip to "B" below)***

If yes, please specify: _____

Are you under the care of a physician for this condition? Y N

Are you taking any medication for this condition? Y N

If so, please list it: _____

(B)

Are you taking lithium? Y N

Are you taking any other medications not listed above? Y N

If yes, please list it: _____

Supplements - If you are currently taking Vitamins, Herbs, or Supplements not listed above, please list:

Name: Dosage:	Reason for taking