Redefined◦Health

Name_____ Date_____

Complaint History

*If you have no symptoms or complaints and are here for Optimal Health or Performance Services, please skip to the **General Health History***

Health Concerns

Please list your health concerns according to their priority for you	Rate Severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain/symptom present
1.					
2.					
3.					

Is condition related to: **Work** Yes No **WCB**? Yes No Motor vehicle accident? Yes No Date?_____

Have you had X-rays, MRI, or other tests for this condition? What tests and when? _____

_____

Did your symptoms start? Suddenly Gradually

What were you doing when your symptoms started? _____

_____

Since the problem started is it: ☐About the same? ☐Getting better? ☐Getting worse?

What makes it worse?_____

_____

_____

What makes it better? _____

_____

_____

How would you describe your symptoms? Dull? Sharp? Ache? Etc.

_____

_____

What have you done for this condition? Did it help?

_____

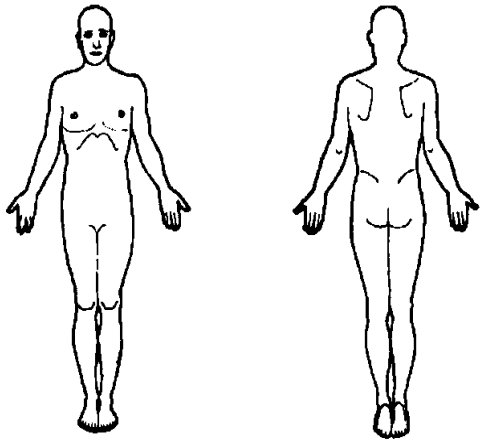
_____

Is this condition interfering with any of the following:

☐ Work ☐ Sleep ☐ Daily routine ☐ Sports/exercise ☐ Other (please explain):_____

_____

Indicate the location of your symptoms by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |

No pain Extreme pain

Can you perform your daily home activities? Yes Yes, only with help Not at all

Can you perform your daily work activities? All activities Only some Not at all

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Name_____Date_____

General Health History

Lifestyle stress can lead to health problems, influence our ability to heal, and affect performance and recovery

Please list any previous surgeries, illnesses, injuries (motor vehicle accident, etc): _____
_____
_____
_____

Please list ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.): _____
_____
_____

Do you exercise? Daily Occasionally Not at all What kind of exercise? _____
_____

Diet

Please indicate how many times a day, week, or month you consume the following (eg. 3x/d, 2x/w, 1x/m):

Fruit	Eggs	Dairy	Wheat
Raw Vegetables	Cooked vegetables	Beef/Bison	Poultry
Fish	Processed Food	Fasting	Whole Grains
Diet food	Weight Control Diet	Refined Sugar	Tobacco
Fried Foods	Organic foods	Seafood	Artificial Sweetener
Pop/Sweetened Drink	Water	Coffee	Alcohol

The type of diet I usually follow is classified as: _____

Stressors Please list your top 3 stresses in each category

Physical stress (falls, accidents, work postures, sports etc.)

_____
_____
_____

Bio-chemical stress (smoke, unhealthy foods, don't drink enough water, drugs/alcohol, etc.)

_____
_____
_____

Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

_____
_____
_____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and mental/emotional):

At work: At home: At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits: Exercise habits: Sleep: General health: Mind set:

How do you grade your physical health?

☐Excellent ☐Good ☐Fair ☐Poor ☐Getting better ☐Getting worse

How do you grade your emotional/mental health?

☐Excellent ☐Good ☐Fair ☐Poor ☐Getting better ☐Getting worse

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Name_____Date_____

Systems Review

Circle any conditions that are ***presently*** causing you a problem. **<u>Underline</u>** those that have caused you problems in the **<u>past.</u>**

GENERAL SYMPTOMS	NEUROLOGICAL	MUSCLE & JOINT	EYES, EARS, NOSE, THROAT
Fever	Visual disturbance	Pain/numbness down arms or legs	Eye pain
Fatigue	Dizziness	Pain between shoulders	Double vision
Sleep disturbance	Fainting	Neck pain / Low back pain	Ringing in ears
Nervousness	Convulsions	Arm pain / Shoulder pain	Trouble swallowing
Weight loss	Headache	Leg pain / Knee pain	Hoarseness
Weight gain	Numbness	Foot pain	Sinus infection
Sweats	Neuralgia (nerve pain)	Swollen joints / Spinal curvature	Nasal drainage
Fainting	Poor coordination	Arthritis / Fractures	Enlarged glands
	Weakness		

RESPIRATORY	CARDIOVASCULAR	GASTROINTESTINAL	FOR WOMEN ONLY
Difficulty breathing	High blood pressure	Ulcers / Colitis	Painful menstruation
Asthma	Low blood pressure	Nausea / Vomiting	Hot flashes
Chronic cough	Rapid beating heart	Constipation / Diarrhea	Irregular cycle
Spitting up phlegm	Slow beating heart	Blood in stool	Cramps or back pain
Spitting up blood	Pain over heart	Gallbladder	Menopausal symptoms
Chest pain	Hardening of arteries	Poor appetite	Incontinence
Wheezing	Swollen ankles	Difficult digestion	Miscarriages
	Poor circulation	Heartburn	Complications with pregnancy
	Palpitations		Pregnant? Y / N Week?
	Cold hand or feet		

Have you ever been diagnosed of told you have any of the following?

High blood pressure	Yes	No	Do you take any medication on a regular basis?	Yes	No
Hardening of the arteries (arteriosclerosis)	Yes	No			
Diabetes	Yes	No	Visual disturbances (blurring, loss, double)	Yes	No
Tuberculosis	Yes	No	Hearing disturbances (loss, ringing, other noise)	Yes	No
Cancer, Where? _____	Yes	No			
Heart or blood diseases	Yes	No	Slurred speech or other speech problems	Yes	No
Bone spurs on the neck bones (cervical sprain)	Yes	No	Difficulty swallowing	Yes	No
			Dizziness	Yes	No
Whiplash injury (flexion-extension injury, cervical sprain)	Yes	No	Loss of consciousness, even momentary blackouts	Yes	No
Have you or any of your relative ever suffered a stroke?	Yes	No	Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body	Yes	No
Were you ever a smoker? From _____ To_____	Yes	No	Sudden collapse without loss of consciousness	Yes	No

Is there anything else which may help to better understand you which has not been discussed?

_____

_____

_____