



Desert Physical Medicine

81765 CA-111 suite #3

Indio, CA, 92201

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: _____

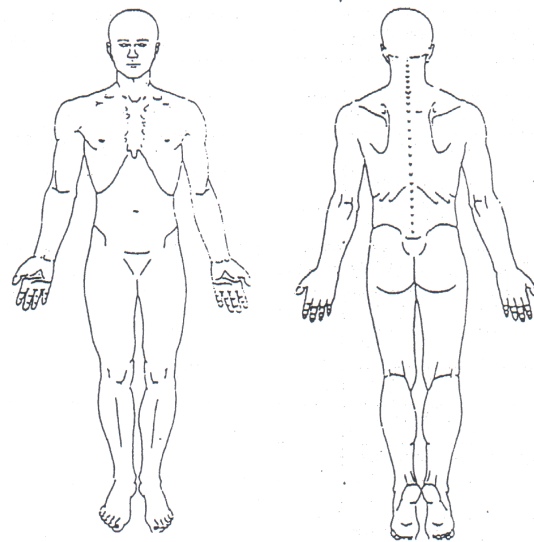
5. Pain Symptoms: a. _____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr) _____
 (In Order b. _____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr) _____
 of Severity) c. _____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr) _____

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 ___
 Herniated Disc ___ Joint Separations ___ Post-herpetic neuralgia ___
 DDD ___ Bursitis ___ Intercostal Neuralgia ___
 Stenosis ___ Sprains ___ Morton's Neuroma ___
 Cartilage injury ___
 (Meniscus Tear, Chondromalacia
 Patellar Syndrome)

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 Exercise (please circle):
Thirst for Water: Yes No _____ Glasses/Day None Very Active
Coffee: Yes No _____ Cups/Day Light Elite Athlete
Soda: Yes No _____ Cups/Day Moderate
Artificial Sweeteners: Yes No Active
Cravings for Sugar: Yes No Type of Exercise: _____
Cravings for Salty Foods: Yes No Frequency of Exercise: _____
Stress Level: High Moderate Low
Alcohol: Yes No _____ Glasses/Day
Smoking: Yes No _____ Cigarettes/Day
Marijuana: Yes No _____ Times/Day
Other Drugs : _____
Occupational Hazards: _____

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

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	_____ Bloating	_____ Gluten Intolerance	_____ Difficulty Swallowing
_____ Acid reflux/Heart burn	_____ Gas	_____ Food Allergies	_____ Diarrhea
_____ Poor Digestion	_____ Hiccups	_____ Chemical Sensitivities	_____ Constipation
_____ Nausea & Vomiting	_____ 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		Other:	_____
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus	Date:	_____
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia		
_____	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 health 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:** _____