Janet L Rueger, DC
541-690-6799

Confidential Health History

Name_____ **DOB**_____**Date**_____
Home Phone_____Cell Phone_____Other_____

If you need more space to answer any of the questions, use the back side of this, please.
Describe problems for which you seek help. Please **include dates** when each problem occurred:

Brief Health History: List major illnesses and accidents. Please include **dates**:_____

List all Surgeries you have had, including **Dental surgeries.** Give **dates**_____

List Medications or Supplements You are presently taking:_____

What **Daily activities** are you finding difficult or are limited because of your above complaints:_____

Have you ever had this problem **before**, and if so, when?_____

Have you been treated for any health condition by **any other health practitioner** in the past year?
_____For what and by whom?_____

Please list any **Medical tests** you have had within the past year:_____

Name_____ DOB_____

Have you ever had extensive **dental or orthodontic** work performed?_____
Do you have any **Root Canals**?_____
Have you had any teeth extracted?_____

Have you had any vaccinations in the past 3 years?_____
If yes, which vaccinations_____
_____
_____
Have you ever had an adverse reaction to a vaccination?_____
If yes, which one(s)_____

Do you wear heel lifts or orthotics?_____ Age of mattress you sleep on_____

Alcohol: How much per week?_____Coffee: How much per day?_____
Black Tea?_____Sodas: How many per week?_____
Do you smoke?_____Chew?_____How much per day?_____
Do you use any "Recreational" drugs?_____
Sugar: Give an estimate of your sugar intake per day or per week_____
How much **WATER** do you drink per day? (other fluids do NOT count as water!)_____

Chemical Exposures-Please list:
Pesticide use either in job or in your own home?_____
Lacquers, paint thinners, paints, especially if they were in contact with your skin_____
Cleaning products, especially if you use them occupationally_____
Working on cars and trucks, other machinery, especially if frequent skin contact_____
Any other chemical exposures_____
Have you ever been diagnosed with: AIDS_____HIV_____Exposed to AIDS_____
TB?_____Hepatitis?_____
Did either of your parents or grandparents have TB, Polio, Syphilis, Gonorrhea, or other serious infectious disease?_____
Any other significant Family History?_____
_____
What are your Goals with care you receive in this office?_____
_____
Is there anything else you would like me to know?_____
_____
_____

_____ _____
Signed Date

Client Name Date of Birth

PART 2.

* Please mark the circle that best describes the frequency you experience the below conditions. **Leave blank if there is never a problem.**

1 Rarely (once a month or less)
2 Occasionally (less than once a week)
3 Frequently (more than once a week)
4 Constantly

DIGESTION

1 2 3 4 Loose stool or Diarrhea	1 2 3 4 Gas or belching	1 2 3 4 Blood in stool
1 2 3 4 Constipation	1 2 3 4 Stomach or intestinal pain	1 2 3 4 Black or dark stool
1 2 3 4 Poor digestion	1 2 3 4 Heartburn	1 2 3 4 Light colored stool
1 2 3 4 Parasites	1 2 3 4 Excessive appetite	1 2 3 4 Difficulty digesting oily food
1 2 3 4 Acid reflux	1 2 3 4 Poor appetite	yes no High cholesterol
1 2 3 4 Hiatal Hernia	1 2 3 4 Irritable bowels	yes no Gall stones
1 2 3 4 Nausea / vomiting	1 2 3 4 Hemorrohoids	

RESPIRATORY

1 2 3 4 Wet cough	1 2 3 4 Nasal problems	1 2 3 4 Other: _____
1 2 3 4 Dry cough	1 2 3 4 Poor sense of smell	yes no Pneumonia
1 2 3 4 Chest tightness	1 2 3 4 Sinus problems	yes no Asthma
1 2 3 4 Shortness of breath	1 2 3 4 Allergies	yes no Emphysema
1 2 3 4 Congestion	1 2 3 4 Hay fever	yes no Bronchitis
1 2 3 4 Wheezing	1 2 3 4 Catches colds easily	yes no Do you smoke? Number per day: ____

CARDIOVASCULAR

1 2 3 4 Hypertension	1 2 3 4 Restlessness	yes no Heart disease
1 2 3 4 Hypotension	1 2 3 4 Heart palpitation	yes no Phlebitis
1 2 3 4 Chest pain	1 2 3 4 Slow heart rate	1 2 3 4 Poor blood clotting
1 2 3 4 Dizziness	1 2 3 4 Poor circulation	yes no Heart attack How many times? ____
1 2 3 4 Easily bruised	1 2 3 4 Blood clots	yes no Stroke How many times? ____
1 2 3 4 Edema	1 2 3 4 Sweaty hands / feet	yes no Other: _____
1 2 3 4 Cold hands / feet	1 2 3 4 Anemia	

URINARY

1 2 3 4 Painful urination	1 2 3 4 Ear aches	yes no Low back pain
1 2 3 4 Incontinence	yes no Hearing impairment	yes no Knee problems
1 2 3 4 Difficulty with urination	yes no Kidney stones	yes no Other: _____
1 2 3 4 Ringing in ears	yes no Kidney infections	

NERVOUS SYSTEM

yes no Dyslexia	yes no Epilepsy	yes no Developmental or growth problems
yes no Learning disorder	yes no Head injury	yes no Nervous disorder? Type: _____
yes no Multiple Sclerosis	yes no Numbness, Where? _____	
yes no Muscular dystrophy	yes no Tingling, Where? _____	

MUSCLES / JOINTS

1 2 3 4 TMJ pain	1 2 3 4 Arm Weakness	yes no Rheumatoid Arthritis
1 2 3 4 Facial pain	1 2 3 4 Trunk Weakness	yes no Artificial joints
1 2 3 4 Loss of Balance	1 2 3 4 Difficulty walking	yes no Broken bones, fractures? _____ _____
1 2 3 4 Poor coordination	1 2 3 4 Joint swelling	
1 2 3 4 Leg Weakness	yes no Osteoarthritis	yes no Pins, etc? _____

Client Name Date of Birth

MUSCLES / JOINTS (cont)

Mark the circle of painful areas, and indicate on which side: (R) right and / or (L) left

yes	no	Shoulder	R L	yes	no	Legs	R L	yes	no	Mid back	R L
yes	no	Arm	R L	yes	no	Knee	R L	yes	no	Low back	R L
yes	no	Elbow	R L	yes	no	Foot	R L	yes	no	Limited movement? Where? _____	
yes	no	Hands	R L	yes	no	Neck	R L				
yes	no	Hip	R L	yes	no	Upper back	R L				

OTHER

1 2 3 4	Insomnia		1 2 3 4	Fatigue		yes	no	Weight loss			
1 2 3 4	Depression		1 2 3 4	Difficulty with speech		yes	no	Tuberculosis			
1 2 3 4	Sleep too much, how long? _____		1 2 3 4	No thirst		yes	no	Thyroid problems			
1 2 3 4	Shaky		1 2 3 4	Excessive thirst		yes	no	Fibromyalgia			
1 2 3 4	Poor memory		1 2 3 4	Dry mouth		yes	no	Poor sense of smell			
1 2 3 4	Difficulty paying attention		1 2 3 4	Pain at night		yes	no	Poor sense of taste			
1 2 3 4	Anxiety		1 2 3 4	Headaches		yes	no	Cancer, Where? _____			
1 2 3 4	Easily angered		1 2 3 4	Migraines		yes	no	Allergies? List: _____			
1 2 3 4	Obsessive tendencies in work relationships		1 2 3 4	Eye pain							
1 2 3 4	Difficulty making plans or decisions		1 2 3 4	Dry eyes		yes	no	Hepatitis? type: ____			
1 2 3 4	Dizziness		1 2 3 4	Watery eyes		yes	no	Infectious disease: _____			
1 2 3 4	Soft or brittle nails		1 2 3 4	Other eye problems? _____		yes	no	Herpes			
1 2 3 4	Intolerance to temperature / weather changes		yes	no	Dental problems	yes	no	Candida			
1 2 3 4	Fever		yes	no	Poor hearing	yes	no	Shingles			
1 2 3 4	Chills		yes	no	Difficulty swallowing	yes	no	Chemical dependency _____			
1 2 3 4	Nose bleeds		yes	no	Diabetes						
1 2 3 4	Swollen glands		yes	no	Weight gain	yes	no	Skin condition: ____ _____			

MEN ONLY

1 2 3 4	Prostate problems		1 2 3 4	Impotence		yes	no	Infertility			
1 2 3 4	Pain associated with genitals		1 2 3 4	Problems urinating		yes	no	Prostate cancer			

WOMEN ONLY

1 2 3 4	Breast pain or tenderness		yes	no	Menopausal symptoms: _____	yes	no	Ovarian cysts			
yes	no	Breast lumps	yes	no	Are your cycles regular? Length of cycle: _____	yes	no	Endometriosis			
yes	no	Nipple discharge	yes	no	Painful menses with heavy or excessive flow	yes	no	PMS			
yes	no	Menopause	yes	no	Painful intercourse	yes	no	Infertility			

WELL BEING

* Please circle any of the following feelings you have experienced in the last few months.

Abused	Paranoid	Unable to grieve	Panic
Criticized	Overwhelmed	Apprehensive	Intolerant
Overworked	Muddled	Agitated	Uncertainty
Paralyzed	Persecuted	Uneasy	Aggravated
Depressed	Guilty	Distress	Annoyed
Rejected	Easily irritated	Fearful	Angry
Despair	Anxious	Impatient	Outraged
Helpless	Sad	Intimidated	Nervous
Hopeless	Grieving	Restless	Worried

* Please mark the circle that best describes the level of stress for the below listings.

My family stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My relationship stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My work stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My financial stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My health stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
Other stress is _____:	◯ None	◯ Minimal	◯ Moderate	◯ Severe

Client Name Date of Birth

How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, etc ?

Do you exercise? And if so, what kind and how often?

How many hours a night do you sleep? _____ Is your sleep restful? _____If not, please explain: _____

PART 3.

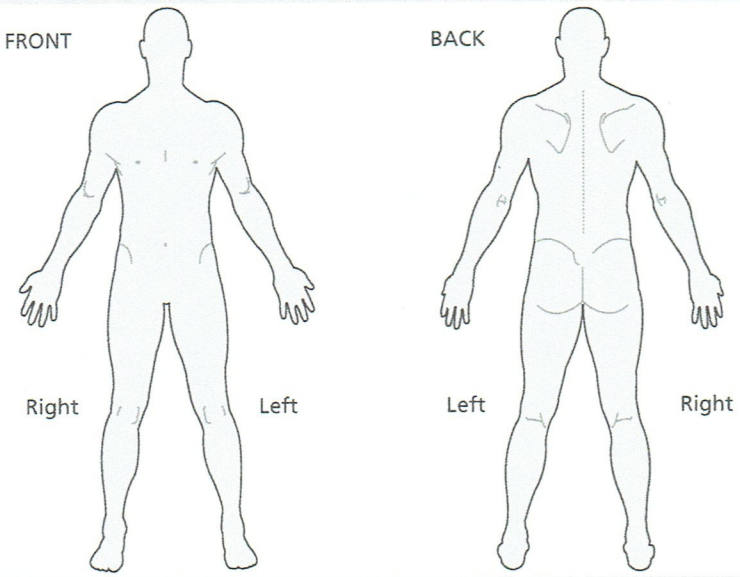
* Please list areas of pain and mark the circle that best describe the level of discomfort on a scale of 1 to 10.

1. Slight awareness of discomfort.
2-3. Awareness of discomfort as an aggravation.
4-6. Pain is strong but you are still functional.
7-9. Pain is so strong you are unable to function normally.
10. You feel like you need to go to the emergency room.

1 2 3 4 5 6 ● 8 9 10 example: neck	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

PART 4.

* Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.



COMMENTS: _____

Practitioner's comments:

Client signature: Date:

Practitioner signature: Date: