The Human Engine Clinic
A Gringeri Chiropractic Corporation
3461 Picadilly Drive, San Jose, CA 95118 | 408-984-7444

WELLNESS HISTORY

Patient's Name: _____ Date _____

1) Have you ever been to a Chiropractor? ❑ Yes ❑ No

If Yes: ❑ Currently ❑ In the past, When: _____ Did it help? _____

If No: What have you heard: ❑ It helps ❑ It hurts ❑ Expensive ❑ It feels good
❑ Not real doctors ❑ You have to keep on going forever ❑ It cracks the bones
❑ Other_____

2) Digestive Section

(Please indicate with a checkmark those statements that apply to you)

Section One

____ 1. Headache
____ 2. Heartburn
____ 3. Bloating and gas pain
____ 4. Constipation or diarrhea
____ 5. Irritability, restlessness, or insomnia
____ 6. Anxiety or depression
____ 7. Stiff, sore joints

Section Two

____ 1. History of ulcers or gastritis
____ 2. Frequent heartburn or indigestion with nausea and pain
____ 3. Acid reflux after eating
____ 4. Frequent use of antacids
____ 5. Pain in stomach that is relieved by eating

Section Three

____ 1. Increased secretions from mouth, nose, eyes
____ 2. Muscle or menstrual cramps
____ 3. Irritated or bleeding gums
____ 4. Cold hands and feet
____ 5. Edema of hands and feet
____ 6. History of gallbladder stones or surgery
____ 7. Loss of appetite, especially for meat
____ 8. Frequent sour taste in mouth, intolerance of fats or spicy foods
____ 9. Have frequent constipation with light colored stool
____ 10. Pain under right rib cage after eating

Section Four

_____ 1. Dry skin, hair loss
_____ 2. Tremors
_____ 3. Slow morning starter, stiffness after rest
_____ 4. Inability to control blood pressure
_____ 5. Inability to conceive, to carry fetus to term, or to induce labor
_____ 6. History of diabetes
_____ 7. High triglyceride and cholesterol levels
_____ 8. High blood pressure
_____ 9. Dizziness or lightheadedness when changing positions
_____ 10. Headache on side of the head and temples

Section Five

_____ 1. Dry mouth, nose, or eyes
_____ 2. Muscle weakness
_____ 3. Patient is easily startled
_____ 4. Inability to concentrate
_____ 5. Difficulty swallowing and voice affected by stress
_____ 6. History of lactose or gluten intolerance
_____ 7. Craving or thirst for cold liquids or foods
_____ 8. Intolerance of dairy products, grains, or sugars
_____ 9. Sensitive to air pollutants, such as perfume and smoke
_____ 10. Tolerates stress very poorly

3) Please check any or the following symptoms you have experienced in the last 6 months:

❑ Headaches/Migraines	❑ Elbow/Wrist/Hand pain	❑ Herniated /Degenerated Disc
❑ Dizziness / Vertigo	❑ Carpal Tunnel Syndrome	❑ Restless Leg Syndrome
❑ Neck pain	❑ Tingling/Numbness	❑ Fibromyalgia
❑ Mid back pain	❑ Lower back pain	❑ Arthritis/Osteoarthritis
❑ Arm/ Shoulder pain	❑ Sciatica (pain in leg)	❑ Stenosis (nerve canal narrowing)
❑ Sinus/Allergies	❑ Hip/Leg pain	❑ Chronic Fatigue / Tiredness
❑ Insomnia	❑ Knee/Ankle/Foot pain	❑ Tremor disorder
❑ Balance Problems	❑ Scoliosis (curved spine)	❑ Digestive problems
❑ High Blood Pressure	❑ Ringing in ear	❑ Whiplash
❑ Diabetes		
❑ Other_____	Females: ❑ Infertility / Menstrual problems	

Do you feel any of these conditions will go away on their own? ❑ Yes ❑ No

4) Since the time you began suffering from these problems, what have you tried to do to get rid of them that has not worked permanently?

❑ Prescription Medications: Results_____
❑ Massage: Results _____
❑ Exercise: Results_____
❑ Physical Therapy: Results _____
❑ Over-the-counter Medications: Results_____
❑ Home remedies: Please explain_____
❑ Other: Please explain_____

5) Describe how the above condition(s) affect you when they are at their worst:

❑ Moody ❑ Irritable ❑ Lose patience with others ❑ Less fun to be with
❑ Help less around the house ❑ Feel Nauseous ❑ Restricted in motion
❑ Have to lie down ❑ Don't want to do anything ❑ Other _____
❑ Interrupts sleep - Explain_____
❑ Restricts daily activities- Explain_____
_____
❑ Hinders recreational activities-Explain _____
_____
❑ They have no affect on me

6) Are you less productive on your job because of these health problems? ❑ Yes ❑ No

Do you enjoy your work less because of these problems? ❑ Yes ❑ No

Do you have to take more breaks? ❑ Yes ❑ No

7) Is there anything else that these problems are preventing you from doing, either totally or partially, that you would really like to be doing again? ❑ Yes ❑ No
Please explain: _____
_____

8) Healing occurs when you are asleep and sleep is essential to a proper immune system. Having problems with sleep is a complicating factor, which makes healing more difficult.

Do you have: 1) Trouble falling asleep due to being uncomfortable? ❑ Yes ❑ No
2) Not enough restful sleep? ❑ Yes ❑ No
3) Awaken in the middle of the night? ❑ Yes ❑ No
4) Waking earlier than you normally would? ❑ Yes ❑ No

9) When was the last time you woke up feeling good? _____

10) Have you just had to learn to live with these problems? ❑ Yes ❑ No

11) Do you feel the quality of your life has decreased as a result of these problems?
❑ Yes ❑ No

12) If these problems go on for another 5-10 years without help, do you feel they will get worse? ❑ Yes ❑ No

How do you feel that would affect you? _____

_____

(Develop arthritis? become bedridden? or become unable to function normally, etc.)

13) Comparing your health now to 5-10 years ago, do you feel your overall health is:

❑ Improving ❑ Getting Worse ❑ Staying the Same

14) What would life be like if you got these problems corrected and they didn't return?

_____

15) Would you feel younger if you didn't have these problems? ❑ Yes ❑ No

How many years younger would you feel? _____

16) We believe that a person's health is more important than anything else.
Without your health, you can't enjoy life. No matter how much money or material possessions a person has, they would always want their health first.

Do you agree that your health should be your top priority? ❑ Yes ❑ No

17) Provided we can help you and accept you for care in our office, do you feel you need to change what you've been doing and get these health problems taken care of?

❑ Yes ❑ No

18) On a scale of 1 to 10, 10 being the most committed and 1 being the least committed, please rate your commitment to getting your health problems handled:

Please circle one: (low priority) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (top priority)

19) Please check off which tests you have had in the past:

❑ MRI ❑ neck – when _____ ❑ low back – when _____
❑ CT SCAN ❑ neck – when _____ ❑ low back – when _____
❑ X-RAYS ❑ neck – when _____ ❑ low back – when _____
For X-rays: Were they taken: ❑ Standing ❑ Seated or ❑ Lying down
❑ Other: _____ when _____ ❑ Other: _____ when _____

A Nutritional Imbalance may cause or contribute to any of the below conditions.

Check off any of the following symptoms you currently have or recently had:

CONDITION	Frequency	CONDITION	Frequency
❑ ADD/ADHD - learning problems		❑ Heart Murmur	
		❑ Hemorrhoids	
❑ Allergies		❑ High Cholesterol	
❑ Allergies - Food		❑ Hypersomnia (sleeping too much)	
❑ Anemia		❑ Hypoglycemia (low blood sugar)	
❑ Arteriosclerosis – Hardening of the Arteries		❑ Infertility / Uterine problems / Miscarriages	
❑ Arthritis / joint pain / DJD / Osteoarthritis		❑ Insomnia	
❑ Asthma / Emphysema		❑ Irregular Heart Rate	
❑ Auto-Immune Disease		❑ Joint Cramps / Pain	
❑ Bed wetting		❑ Kidney Problems	
❑ Bladder / Urination Problems		❑ Libido Decreased	
❑ Bloating		❑ Liver problems	
❑ Blood Pressure-high / low		❑ Low Resistance to Infections	
❑ Bronchitis / cough / Breathing problems		❑ Male = Prostate problem / Impotence	
❑ Cancer		❑ Memory Loss (loss of concentration)	
❑ Candida Albicans / Yeast Infections		❑ Menopause / hot flashes	
❑ Chest Pain / Pneumonia		❑ Numbness / Tingling	
❑ Colds (chronic) / sore throat / Tonsillitis		❑ Osteoporosis	
❑ Constipation		❑ Over / Under Weight	
❑ Depression		❑ PMS / Menstrual problems / cramps	
❑ Diabetes (high blood sugar)		❑ Poor Circulation / Cold hands or feet	
❑ Diarrhea / Digestive Problems / Colitis / Gas		❑ Psoriasis	
❑ Dizziness / Vertigo / Imbalance / Falling		❑ Rapid Heart Rate	
❑ Ear Infections / Earaches		❑ Seizures	
❑ Eye Trouble / Vision difficulty		❑ Shingles	
❑ Edema / water retention (swelling feet)		❑ Shortness of Breath	
❑ Epilepsy		❑ Sinus Problems	
❑ Failed Back/ Neck/ Wrist Surgery		❑ Skin Disorders / Eczema / Hives / Acne	
❑ Fainting Spells		❑ Stiffness	
❑ Fatigue / Exhaustion / Low energy		❑ Stomach Problems / Nausea / Indigestion	
❑ Fibromyalgia		❑ Thyroid Disorder	
❑ Gall bladder problems		❑ TMJ	
❑ Headaches (non-migraine)		❑ Ulcer	
❑ Headaches - Migraine		❑ Varicose veins	
❑ Hearing problems		❑ Weakness or cramps in legs	
❑ Heart Disease – Cardiovascular Disease		❑ Weight gain / loss	

Any other complaints or concerns that you wish you could get rid of, even if you wouldn't necessarily think that it's something we could help you with: _____

What Prescribed Medications are you currently taking?

_____

_____

_____

_____

_____

What Over-The-Counter Medications are you taking?

_____

_____

_____

What Supplements are you taking? _____

_____

_____

Do you have a history of:

- ❑ Kidney Stones? Date_____
- ❑ Gall Stones? Date_____
- ❑ Heart Attack? Date_____
- ❑ Stroke? Date_____
- ❑ Surgery? -For_____
  Date_____
  -For _____
  Date_____
- ❑ Other_____