

Holly Waite, DC

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PLEASE PRINT

**Practice Member Information**  File#\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Last Name­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI\_\_\_\_Age\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Race\_\_\_\_\_\_\_\_\_Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M F Marital Status: Single Married Widowed Divorced SS#\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_# of Children\_\_\_\_\_\_\_\_Names, Ages, & Gender\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom May We Thank for Referring You?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient’s Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Native Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # Cell(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_Home(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_Work(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # Cell(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_Home(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_Work(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**Health History Information**

Have you had previous chiropractic care? Y N

If so, who was your previous chiropractor?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was your reason for your visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you given home care to help with this condition? \_\_\_\_Y\_\_\_\_N

Did you follow the doctor’s recommendation’s? \_\_\_\_Y\_\_\_\_N

Where X-rays taken in the last 6 months? Y N

Are you wearing: Heel Lifts Custom Orthotics

**Reason(s) for Seeking Chiropractic Care (Starting With the Most Severe):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Health Concern(s):(Most Severe First) | When Condition Started Or For How Long? | Have you had this before?**Y/N****When**? | Rate Severity**0**=No Pain**10**=Extreme Pain | Injury Related?**Y/N** | Constant **(C)** or Intermittent **(I)**? |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |

Which of these is worst?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Since your problem started, is it? \_\_\_\_About the Same\_\_\_\_Getting Better\_\_\_\_Getting Worse

What makes it better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When does it occur? (morning, afternoon, evening, with certain activities, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it radiate or shoot anywhere?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen any other doctors for this condition? \_\_\_\_\_Chiropractor\_\_\_\_\_Medical Doctor\_\_\_\_\_Other

If so, WHO & WHEN?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List any Surgeries, Hospitalizations, & Dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all MEDICATIONS you are currently taking or have taken, for what condition, & for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date and Reason for last visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact your doctor regarding your care at our office if necessary? \_\_\_\_Y\_\_\_\_N

Naturopathic Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date and Reason for last visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact your naturopathic doctor regarding your care at our office if necessary? \_\_\_\_Y\_\_\_\_N

Have you ever been in a motor vehicle accident (even if minor)? \_\_\_\_Y\_\_\_\_N

 If yes, what kind and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you evaluated and treated after each accident? \_\_\_\_Y\_\_\_\_N

Have you had any non-vehicle accidents or falls? \_\_\_\_Y\_\_\_\_N

Have you ever been knocked unconscious? \_\_\_\_Y\_\_\_\_N

Fractured any bones? \_\_\_\_Yes\_\_\_\_No If Yes, Please Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other bodily trauma?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**As a Child:**

To your knowledge, was your delivery difficult? \_\_\_\_Y\_\_\_\_N

Describe Your Birth: \_\_\_\_Forceps \_\_\_\_Vacuum \_\_\_\_Cesarean \_\_\_\_Breech \_\_\_\_Natural Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you breast fed? \_\_\_\_Y\_\_\_\_N For how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you experience emotional trauma as a child? \_\_\_\_Y\_\_\_\_N Physical trauma? \_\_\_\_Y\_\_\_\_N

Did you have any accidents, falls, or injuries? \_\_\_\_Y\_\_\_\_\_N If Yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

****Were you given antibiotics as a child? \_\_\_\_Y\_\_\_\_N

Did you have ear infections as a child? \_\_\_\_Y\_\_\_\_N Any major childhood illness? \_\_\_\_Y\_\_\_\_N

Were you vaccinated as a child? \_\_\_\_Y\_\_\_\_N Any adverse reactions? \_\_\_\_Y\_\_\_\_N

Please Mark **Any** and **All** Conditions You **Have** or **Have Had in the Past**

& Mark **C** for **Current** OR **P** for **Past**

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_Asthma | \_\_\_\_Chronic Sinus | \_\_\_\_Leg/Foot Pain R/L | \_\_\_\_Nausea |
| \_\_\_\_Allergies | \_\_\_\_Thyroid Issues | \_\_\_\_Menstrual Issues | \_\_\_\_Reflux |
| \_\_\_\_Headaches | \_\_\_\_ Heart Problems | \_\_\_\_Infertility  | \_\_\_\_Ulcers  |
| \_\_\_\_Migraines | \_\_\_\_Chest Pain R/L | \_\_\_\_Digestive Issues | \_\_\_\_Arthritis  |
| \_\_\_\_Dizziness | \_\_\_\_Hand/Arm Numbness R/L | \_\_\_\_Knee Problems R/L | \_\_\_\_Lupus |
| \_\_\_\_Vertigo | \_\_\_\_Shoulder Pain R/L | \_\_\_\_Liver Disease  | \_\_\_\_TMJ |
| \_\_\_\_ Ear Infections | \_\_\_\_Arm/Hand Pain R/L | \_\_\_\_Kidney Problems | \_\_\_\_GERD |
| \_\_\_\_ADD/ADHD | \_\_\_\_Mid Back Pain | \_\_\_\_Bladder Problems | \_\_\_\_Anxiety  |
| \_\_\_\_Neck Pain | \_\_\_\_Low Back Pain | \_\_\_\_Sciatica R/L | \_\_\_\_Epilepsy |
| \_\_\_\_Neck Stiffness | \_\_\_\_Hip Pain R/L | \_\_\_\_Leg/Foot Numbness R/L | \_\_\_\_Pregnant  |
| \_\_\_\_Fibromyalgia  | \_\_\_\_Chronic Fatigue | \_\_\_\_ Anemia | \_\_\_\_Insomnia |
| \_\_\_\_Scoliosis  | \_\_\_\_Disc Problems | \_\_\_\_Depression | \_\_\_\_Irritable |
| \_\_\_\_Eating Disorders | \_\_\_\_High Blood Pressure | \_\_\_\_Low Blood Pressure | \_\_\_\_ HIV/AID |
| \_\_\_\_ Diabetes | \_\_\_\_Cold Hands or Feet | \_\_\_\_Nervousness |  |
| \_\_\_\_High Stress | \_\_\_\_Frequent Colds/Flus | \_\_\_\_Vision Changes |  |
| \_\_\_\_Mood Changes  | \_\_\_\_Skin Problems | \_\_\_\_Prostate Problems |  |
| \_\_\_\_Impotence  | \_\_\_\_Gallbladder Problems | \_\_\_\_Learning Disabilities  |  |
| \_\_\_\_Hearing Loss | \_\_\_\_Ringing in Ears | \_\_\_\_Concentration Loss |  |
| \_\_\_\_Nose Bleeds | \_\_\_\_Pain With Cough/Sneeze | \_\_\_\_Blurry/Double Vision |  |

Any other health issues not mentioned above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Mark **Any** and **All** Conditions You **Have** or **Have Had in the Past**

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL FRACTURE SCOLIOSIS DIABETES

**Health/Risk Factors & Comments:**

Do you smoke? \_\_\_\_Y\_\_\_\_N Amount?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is your job stressful? \_\_\_\_Y\_\_\_\_N

Do you drink alcohol? \_\_\_\_Y\_\_\_\_N Amount?\_\_\_\_\_\_\_\_\_\_\_\_\_Do you sleep well? \_\_\_\_Y\_\_\_\_N Hrs?\_\_\_

Do you have a healthy diet? \_\_\_\_Y\_\_\_\_N Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? \_\_\_\_Y\_\_\_\_N Describe?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Times/Wk:\_\_\_\_\_\_\_\_\_\_\_

Do you have any silver amalgam fillings? \_\_\_\_Y\_\_\_\_N How many?\_\_\_\_\_\_\_\_

How long have you had them?\_\_\_\_\_\_\_\_\_\_\_\_\_

****Have you been vaccinated? \_\_\_\_Y\_\_\_\_N Do you get annual flu shots? \_\_\_\_Y\_\_\_\_N

Do you have any red ink tattoos? \_\_\_\_Y\_\_\_\_N How many?\_\_\_\_\_\_\_

Have you ever noticed any drastic decline changes in your health? \_\_\_\_Y\_\_\_\_N When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the issue ever diagnosed? \_\_\_\_Y\_\_\_\_N Resolved? \_\_\_\_Y\_\_\_\_N

**What are your health goals?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How do you expect to achieve these goals?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**