Barefoot Chiropractic & Wellness

2919 S. Ellsworth Rd., Ste. 109

Mesa, AZ 85212

480-357-5555

Patient Profile

Date:

Patient Name: _____ **DOB:** _____

List in Order of importance what your problems are: **Age:** _____

1) _____

2) _____

3) _____

4) _____

5) _____

Last time you had blood work done and with what physician: _____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for death:						
Cancer type:						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please Note If/When/Why You Have Had Each of the Following:

X-Rays: _____ MRI/Cat Scans: _____

Ultrasounds: _____ Accidents: _____

HIV: _____ Hepatitis C: _____

Last Dental Visit: _____ Last Eye Exam: _____

TB Test: _____

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

Measles: D I N **Chicken Pox**: D I N **Mumps**: D I N **Rubella**: D I N

Tetanus: D I N **Whooping Cough**: D I N **Hemophilus (Hib)**: D I N **Hepatits B**: D I N

German Measles: D I N **Any vaccination reactions:** ___

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Antacids: Y N P **Steroids**: Y N P **Smoking**: Y N P **Packs per day & number of years**: _____

Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day if Yes/Past**: _____

Soda Pop: Y N P **Ounces per day if Yes/Past**: _____

Alcohol: Y N P **How often & how much if Yes/Past**: _____

Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P

Recreational Drugs: Y N P **Any Drug Addictions**: Y N P

Any Drug Treatment: Y N P

List any Supplements (vitamins/minerals/herbs) that you are taking and include dosage if known:

_____

_____

_____

Review of Systems:

Present Weight: _____ **Weight one year ago**: _____ **Height**: _____

Maximum weight and when: _____ **Minimum weight as adult & when**: _____ **Ideal Weight**: _____

REGARDING THE NEXT SECTION: Please circle **(Y)** if you're *currently* experiencing, **(N)** if you're *not* experiencing, or **(P)** if you have a *past* history.

Good Energy: Y / N / P

Fatigue: Y / N / P

If you have fatigue, when is it the worst? Morning / Afternoon / Evening

If you have fatigue, can you do what you need to during the day? Y / N

SKIN				
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer:	Y N P		**Perspiration:**	Y N P

HEAD				
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P
NOSE				
Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Post Nasal Drip:**	Y N P
Polyps:	Y N P		**Seasonal Allergies:**	Y N P
EYES				
Dry/Watery:	Y N P		**Blurry Vision:**	Y N P
Double Vision	Y N P		**Cataracts:**	Y N P
Glaucoma:	Y N P		**Styes:**	Y N P
Strain:	Y N P		**Discharge:**	Y N P
Itchy:	Y N P		**Dark under Eyelid:**	Y N P
MOUTH/THROAT				
Canker sores:	Y N P		**Cold sores:**	Y N P
Sore Throat:	Y N P		**Gum disease:**	Y N P
Dentures:	Y N P		**Cavities:**	Y N P
Loss of taste:	Y N P		**Hoarseness:**	Y N P
NECK				
Stiffness:	Y N P		**Swollen Glands:**	Y N P
Full movement:	Y N P		**Tension:**	Y N P
RESPIRATORY				
Cough:	Y N P		**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P		**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P		**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P		**Asthma:**	Y N P
Wheezing:	Y N P		**Painful breathing:**	Y N P
CARDIOVASCULAR				
High Blood Pressure:	Y N P		**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P		**Murmurs:**	Y N P
Arrhythmias:	Y N P		**Palpitations:**	Y N P
Edema:	Y N P		**Chest Pain:**	Y N P
URINARY TRACT				
Incontinence:	Y N P		**Pain w/ Urination**	Y N P
Frequent Infections:	Y N P		**Kidney Stones**	Y N P
Urgency:	Y N P		**Discharge/Blood:**	Y N P

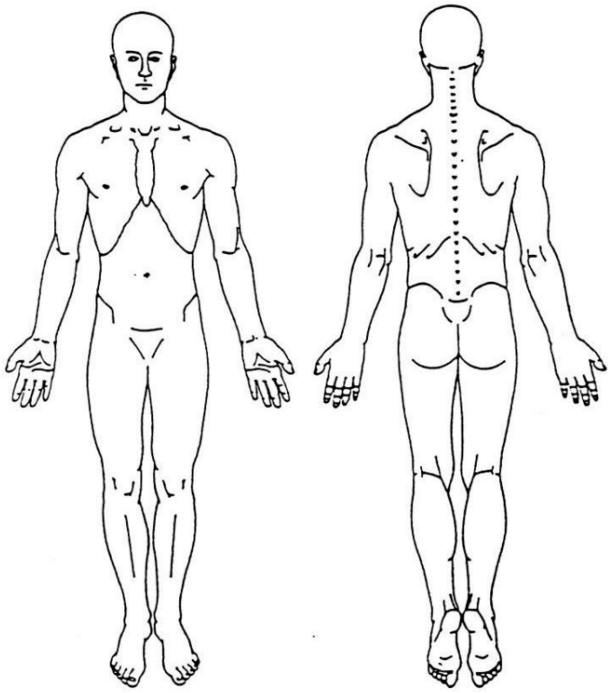
GASTROINTESTINAL				
Heartburn:	Y N P		**Bowel Movements (BM) / Day:**	
Indigestion:	Y N P		**Recent BM Change:**	Y N P
Bloating:	Y N P		**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P		**Hemorrhoids:**	Y N P
Vomiting:	Y N P		**Gall Bladder Disease**	Y N P
Change in Appetite:	Y N P		**Liver Disease:**	Y N P
Pancreatitis:	Y N P		**Ulcer**	Y N P
MALE GENITALIA				
Testicular pain/swelling:	Y N P		**Sexually Active:**	Y N P
Hernia:	Y N P		**S.T.D.:**	Y N P
Discharge:	Y N P		**Prostate Disease/Symptoms:**	Y N P
Impotency:	Y N P		**Sexual Orientation:**	Hetero Homo Bi
FEMALE GENITALIA				
Age Period Began:			**How Often Period Occurs:**	
How long period lasts:			**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P		**Menstrual Pain:**	Y N P
PMS:	Y N P		**Currently Pregnant:**	Y N
Times Pregnant:			**How many births:**	
Miscarriages:			**Abortions:**	
Last Pap Smear:			**Diagnosis:**	
Any abnormal paps:	Y N P		**When was abnormal:**	
Menopausal since what age:			**Use of hormones:**	Y N P
Vaginal symptoms:	Y N P		**Breast symptoms:**	Y N P
Healthy libido:	Y N P		**Sexually Active:**	Y N P
Pain w/ Intercourse:	Y N P		**Contraception:**	Y N P
S.T.D.:	Y N P		**If Yes, what type?**	
Dexa Scan/Mammography:	Y N P		**If Yes, date/results?**	

Please list any birth control used and ages used: _____

_____

MUSCULOSKELETAL			
Pain:	Y N P	**Locking:**	Y N P
Stiffness:	Y N P	**Popping:**	Y N P
Swelling:	Y N P	**Grinding:**	Y N P
Strain/Sprain:	Y N P	**Arthritis:**	Y N P
Fracture:	Y N P	**Tendonitis:**	Y N P

Please circle where your current symptom(s), if any, are located on the diagram below along with a corresponding description/label of the symptom(s) and severity scale 0-10 (10 being worst):



NERVOUS			
Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P
Mental/Emotional			
Depression:	Y N P	**Anger/irritability:**	Y N P
Suicidal:	Y N P	**High-strung/tense:**	Y N P
Anxiety:	Y N P	**Fear/Panic**	Y N P
Eating disorder:	Y N P	**Psych Hospitalization:**	Y N P

Diet

Breakfast: _____ **Lunch:** _____

Dinner: _____ **Snacks**: _____

Drinks (water, coffee soda, juice, etc.): _____

Exercise

How often do you exercise? _____ **What type of exercise**? _____

For how long? _____ **Hobbies**: _____

Sleep

How long per night? _____ **If you wake up frequently, what is the reason**? _____

Nightmares: Y N P **Wake Refreshed**: Y N P **Must nap during the day**: Y N P

Sleep walk: Y N P **Grind teeth**: Y N P **Snore**: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

Social Life

Enjoy job: Y N P **Hours worked per week**: _____ **Highest Level of Education**: _____

Active spiritual practice: Y N P

Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: Y N **P**

If so, at what age and by whom: _____

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: Little Moderately Very