Imaging ?

History Questionnaire

hands on back space.

Name: [redacted]

Date: 5/29/24

Date of Birth: Age 60

Email:

Phone:

Please tell me your most important health concerns at this time. Scoliosis

What other health concerns do you have at this time?

1. Constipation
2.
3.

Please list other doctors, chiropractors, acupuncturists and physical therapists you see and for what:

1. Dr Thomas Forest, Pleasanton - upper cervical
2.
3.

List prescription medicine you now take (include dosage, reason you take it):

Medication	Dose per Day	How long? Reason for medication
None		
Rare Matrin--		

Please list over-the-counter medicines, vitamins, and food supplements you take and why?:

Supplement	Dose per Day	How long? Reason for medication
lCaMg		
B'		
My glycinate		
D- oil		
Niacinamide.		

Are there any adverse effects from any of the above? If so what is it and is it a concern?

No

Medical History (Please include dates):

Any Major illnesses that have been diagnosed or suspected:

Illness	When?	How diagnosed? (lab, imaging, symptoms)
O		

Injury/Trauma/Accidents

What? What was injured?	When?
O	

Surgeries/Hospitalizations:

Surgery/Hospitalization	When?
Uterine cyst	2014
Skin Ca	
Bunionectomy -	

Anaphylactic Reactions or severe reactions (medications, food, stings) to:

Sensitivities (medication, supplements, foods, etc.)
Gluten

Recent Medical Care: Where did you last receive medical care? _____

For what reason(s)? _____

Date of last physical exam: _____ Date of last lab work: _____

Do you visit the dentist annually or more frequently? Y N
Characterize your dental health Poor Fair Good (Great)
Gum-periodontal health Poor Fair Good (Great)
Height 5'5 Weight 120 Max weight 140 Desired weight 115

Circle if the symptom has occurred in the **last year**. Please **check mark** if the symptom occurred in **the past**, **1** for not often, **2** for occasional, **3** for often.

General	Weight gain (Weight loss) Weight gain (20lbs) Weight loss (20 lbs) History of dieting	Chronic fatigue (Afternoon fatigue) Weakness Excessive thirst Anemia	Spontaneous sweating Night sweats Fever/chills	Heat intolerance Cold intolerance Cold hands/feet Other:
Skin	(Dry skin) Itchy skin Rashes Hives Bruise easily	Acne Eczema Psoriasis Shingles Fungal Rash/ringworm	Athlete's foot Nail fungus Moles Varicose veins Bumpy skin back of arms	Any change to nails Any change to skin color Any change to moles Other:

Head	Headaches (Migraines)	Dizziness Vertigo	Trauma Hair Loss	Seizures Other:
Eyes Last exam___	Dry eyes Watery eyes Itchy eyes Eye pain Red eyes Eye discharge	Blurred vision Double vision Sensitive to light Poor night vision	Styes Cataracts Vision loss Other:	Vision correction: Nearsighted Farsighted Contacts Glasses Laser

oce nightsweats lays down oce.

Ears	Ear pain Itchy ears Waxy ears	Discharge from ears Ringing in ears Hearing loss	Ear infections Ear infections as child	Hearing Aids Other
Nose & Sinuses	Itchy nose Discharge from nose Phlegm	Hay-fever/Allergies Post nasal drip Nosebleeds Loss of smell	Breathes thru mouth Snores	CPAP use Other:
Mouth & Throat Last dental exam ____	Dry mouth Itchy mouth/lips Sores on mouth/lips Bad breath	Sore throat Difficulty swallowing Loss of taste Hoarseness	Dentures Inflamed/bleeding gums Teeth sensitivity Braces	Jaw clicking TMJ
Neck	Neck pain scoliosis related	Swollen glands	Trauma	Other:
Respiratory	Shortness of breath Wheezing Pain with breath Coughing up blood	Asthma Bronchitis/Pneumonia Persistent cough	Exposure to: Chemicals Solvents Particulates	Tuberculosis Other:
Cardiovascular Last EKG ___	High blood pressure Low blood Pressure High Cholesterol Chest pain Heaviness in legs Bleeding issues	Heart races Palpitations Chest tightness Difficulty breathing at night Swelling in ankles Stroke	Cold hands/feet Purple fingers/lips Heart murmur Dizzy on standing Exhaustion with mild exertion * palps - food related.	Clots Varicose veins Spider veins Calf pain-night Calf pain-walking Other:
Gastrointestinal (upper) Last endoscopy -----	Poor appetite Excessive appetite/thirst Changes in appetite Trouble swallowing Stomach pain	Nausea Vomiting Burping Belching Heartburn H. pylori Ulcers	Intolerance to foods: (list foods)	Fatigue after eating Anal itching Liver disease Gall bladder disease Treated for parasites
Gastrointestinal (lower) Last colonoscopy ___ Last rectal exam ___	Abdominal pain Abdominal bloating Gas/flatulence History of abdominal/pelvic surgery	Constipation <1 stool a day Painful Stool Hemorrhoids Blood in stools Blood on stools	Stool hard to pass Foul smelling stool Loose stools Frequent stools >3 day Undigested food in stools	Stool shape: - one piece -little pellets - breaks up -other: Color: -yellow -green -brown - black

Chiro to fix neck
Lies R side pushes on L

squat + garden - arms out
really issue neck

Kidney/Urinary	Frequent urination Urinate <3x day Can't hold urine Urination with cough or sneeze	Kidney infections Bladder infections Urination at night Pain/burning with urination	Dripping after urination Bed-Wetting Other:	Color: Light yellow Dark yellow Red urine Cloudy Strong smelling
Musculoskeletal	Pain in- Arms Shoulders Neck Hands Upper back Lower back Hips Legs Knees Feet	Painful bones Tight Shoulders Pain Muscles Swollen knees/elbows Burning Spasms/cramps Morning stiffness	Chronic pain Loss of height Osteoporosis Unable to sit straight Activities Limited due to pain	Herniated/bulging disc Arthritis Rheumatoid arthritis Tendonitis # Broken bones __ DEXA Y N When____ Normal?
Neurological	Fainting Dizziness/vertigo Numbness/tingling Where? _____ Trembling hands	Poor Concentration Memory loss -long-term -short term Lack of alertness	Loss of grip Loss of muscle tone Muscle weakness Head heavy Heavy extremities	Head trauma Other:
Endocrine	Hypothyroid - surgical -Hashimoto's -unknown cause Hyperthyroid Cold hands/feet Cold intolerance	Hypoglycemia Hyperglycemia -DM1 -DM2 -Medications Y N Excessive thirst	Fatigue Poor appetite Excessive Hunger	Unexplained weight gain / loss Other:
Immune	Slow wound healing Reactions to Vaccines Cancer Mononucleosis	Chronic fatigue syndrome Auto immune disorder _____	Chronically swollen glands Chronic Infections Chicken pox Shingles	Frequent colds/flus Herpes Warts Other:
Women only	Menses: Age of first: 16 Days bleed:____ Length of cycle:____ Date of last menses: Heaviest flow day: ____ Heavy days #pads/tampons: Clots? Cramps 1 2 3 4 5 Medication Y N Occ Hysterectomy____ Fibroids Cystic Pain	Sexually active Y N # Pregnancies ____ # Live births 3 Gender you are sexually active with? Men Women Both Type of birth control? -Birth control pills -IUD Cu+ / Hormone -Condoms -Implant -Depo shot - Vasectomy -Other	Spotting between menses PMS -irritability -moodiness -crave sweet -crave salt -bloating -breast tenderness -crave salt Fatigue with menses Miss menses Irregular menses	Vaginal -itching -discharge -odor -dryness Infections -yeast -bacterial -viral History of STI Y N _____ Difficulty conceiving Libido 1-5 ____

Pain – R lowback R neck base skull.

Women only	Breast Monthly self exam Y N Fibrous breast Breast fed a child Implants Reduction Nipple discharge	History of mammogram Abnormal mammogram + PAP history -Cryo -LEEP	Menopause Age __Yrs ago 10 Hot flashes Night sweats Moodiness Brain fog Vaginal dryness	Hormone replacement -standard -natural - herbal Other:
Men only PSA test___ Prostate exam____	Sense of full bladder Difficulty urinating Pain with urination Wake >1x to urinate Dripping after urination Strain with urination Discharge from penis Sore on penis	Discharge from penis Sore on penis History of STI Y N Premature ejaculation Erectile dysfunction Sexual difficulties Libido 1-5 __	Testicular pain Testicular lump Testicular monthly exam Y N History of prostatitis Pain in genitals Hernia	Sexually active Y N Gender you are sexually active with? Men Women Both Type of birth / STI control? Vasectomy Condoms _____
Emotional & Mental	Unexplained crying Loss of interest Boredom Restless Panic attacks Aggression	Self-blame Excessive guilt Socially withdrawn Irritability Worry Loss of confidence / self-esteem	Indecisiveness Inability to concentrate Anxiety Overly concerned with social encounters Thought of suicide	Memory impaired -recall words -learn new tasks Unable to recognize or identify objects Disturbance in planning or execution of plan
Sleep	Difficulty falling Difficulty staying Wake refreshed	Wake catching breath Snore Wake tired	Hours sleep ___ Hours Sleep needed ___	Apnea Treatment Y N
Exercise	Never 0-2 x week 2-5 x week 5 + x week	Intense Moderate Easy going	Bike Swim Hike Weights Run Gym walk hills	Other:
Lifestyle	Spiritual participation Yoga Tai chi Chi kung Meditation Other: Rosary	Art Knitting Quilting Drawing Photography Other _____	Married ____ # Children # Children living with you 3	Use of Daily/Weekly/Monthly Alcohol M Marijuana ____ Tobacco ____ Other ____

Average Diet (what you eat)	Breakfast When What:	Lunch When What:	Dinner When What:	Snacks When What:
Quantity ? **Water** **Coffee** **Tea** **Wine** **Beer** **Cocktail** **Other:**	eggs toast coffee Beverages coffee	smoothie greens fruit slice chicken Beverages water	meat / fish veggies Beverages water	avacado fruit honeycomb coconut yoghurt Other Beverages tea Kombucha

Family History? Who?

Alcoholism
Arthritis
Asthma
Cancer Type Stomach - dad
Arthritis
Asthma
Diabetes
Heart Disease (hypertension, CAD, Stroke) mom
Mental illness
Gastrointestinal
Thyroid
Autoimmune

Rate your stress level (1=low 10=very high) 1 2 3 4 5 6 (7) 8 9 10
Circle and rate the contributors
Health 7 Work 1 Money 6 Kids 6 Marriage 1 Parents 1
Home 1 Other _____

In your everyday life, your present faith/spiritual practices are (1=Important, 10= very important) 1 2 3 4 5 6 7 8 9 (10)
Please rate your **motivation** to affect change in your health (1= unmotivated, 10= highly motivated) 1 2 3 4 5 6 7 8 9 (10)

Tell me your Hobbies:
garden pets church art
Do you actively engage in interests or hobbies? yes

Addendum For Yoga Therapy

Prioritizing your **physical** body (skeletal, muscles, pain) name the most limiting to your life to the least limiting.

1. Back
2 Neck
3

Do you have mobility restrictions? What are they? just pain.

How would you describe your breathing? ?

When is your energy elevated and deficient?

Season? Elevated spring Deficient winter

Time of day? Elevated late morning Deficient evening.

What would you change about your sleep? - stay asleep more

Overall How is your digestion (1=poor – 10=great) 5

Food preferences (circle all apply) salty sour sweet pungent spicy bitter

Diet is % wise meat 75% fish 25% veg raw 10% 90% cooked. grain = pot.

processed 5% homemade 90% fast food ∅ good restaurant 5%

Meals per Day 3 When 9am 12pm 5pm

Do you require motivation? No

Three Words that describe your personality 1 skeptical

2. curious 3. friendly

What is deeply meaningful to you? family

How much do you devote to this? 75%

How do you Cope with stress or difficult issues? exercise + garden.

Circle those above you consider positive

What would you like to learn or teach others?

What do you do that **brings you joy**? kids, friends, books photography + pets

Thank you and please add anything else.