

HEALTH HISTORY

Name: _____ Date: _____

Age: _____ Birthday: _____ Date of last physical examination: _____

What is your reason for this visit? _____

SYMPTOMS Check symptoms you currently have or have had in the past year.

<p style="text-align: center;">GENERAL</p> <p><input type="checkbox"/> Sweats</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Loss of Weight</p> <p><input type="checkbox"/> Loss of Sleep</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Forgetfulness</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Chills</p>	<p style="text-align: center;">EYES</p> <p><input type="checkbox"/> Blurred Vision</p> <p><input type="checkbox"/> Vision- Halos</p> <p><input type="checkbox"/> Vision- Flashes</p> <p><input type="checkbox"/> Double Vision</p> <p><input type="checkbox"/> Crossed Eyes</p>	<p style="text-align: center;">NEUROLOGICAL</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Vertigo</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Hand Trembling</p> <p><input type="checkbox"/> Loss of Sensations</p> <p><input type="checkbox"/> Loss of Facial Expression</p> <p><input type="checkbox"/> Weak Grip</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Difficulty of Speech</p> <p><input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Loss of Memory</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Un-coordination</p>	<p style="text-align: center;">CONDITIONS</p> <p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bleeding Disorders</p> <p><input type="checkbox"/> Breast Lumps</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Breath Shortness</p> <p><input type="checkbox"/> Bulimia</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Chemical Dependency</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> HIV Positive</p> <p><input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Migraine Headaches</p> <p><input type="checkbox"/> Miscarriage</p> <p><input type="checkbox"/> Mononucleosis</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Polio</p> <p><input type="checkbox"/> Prostate Problem</p> <p><input type="checkbox"/> Psychiatric Care</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Scarlet Fever</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Suicide Attempt</p> <p><input type="checkbox"/> Thyroid Fever</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Vaginal Infections</p> <p><input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> Other _____</p>
<p style="text-align: center;">EAR/NOSE/THROAT</p> <p><input type="checkbox"/> Persistent Cough</p> <p><input type="checkbox"/> Difficulty Swallowing</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Bleeding Gums</p> <p><input type="checkbox"/> Nose Bleeds</p> <p><input type="checkbox"/> Sinus Problem</p> <p><input type="checkbox"/> Hay Fever</p> <p><input type="checkbox"/> Loss of Hearing</p> <p><input type="checkbox"/> Ringing in Ears</p> <p><input type="checkbox"/> Ear Discharge</p> <p><input type="checkbox"/> Earache</p>	<p style="text-align: center;">RESPIRATORY</p> <p><input type="checkbox"/> Distress <input type="checkbox"/> Sputum</p> <p><input type="checkbox"/> Cough <input type="checkbox"/> Congestion</p> <p><input type="checkbox"/> Shortness of Breath</p>	<p style="text-align: center;">INTEGUMENTARY</p> <p><input type="checkbox"/> Scars</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Sores</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Unusual Swelling</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Sores that won't heal</p> <p><input type="checkbox"/> Changes in Moles</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Bruise Easy</p>	<p style="text-align: center;">CARDIOVASCULAR</p> <p><input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> Swelling of ankles</p> <p><input type="checkbox"/> Rapid Heart Beat</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> Irregular Heart Beat</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Chest Pain</p>
<p style="text-align: center;">WOMEN ONLY</p> <p><input type="checkbox"/> Abnormal Pap Smear</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Breast Lumps</p> <p><input type="checkbox"/> Extreme Menstrual Pain</p> <p><input type="checkbox"/> Hot Flashes</p> <p><input type="checkbox"/> Nipples Discharge</p> <p><input type="checkbox"/> Painful Intercourse</p> <p><input type="checkbox"/> Vaginal Discharge</p> <p><input type="checkbox"/> Other _____</p> <p>_____ Date of Last Period</p> <p>_____ Date of Last Pap Smear</p> <p><input type="checkbox"/> Have you had a mammogram? _____</p> <p><input type="checkbox"/> Are you Pregnant? _____</p> <p>_____ Number of Children</p>	<p style="text-align: center;">MUSCLE/JOINT/BONE</p> <p><input type="checkbox"/> Arms</p> <p><input type="checkbox"/> Hips</p> <p><input type="checkbox"/> Back</p> <p><input type="checkbox"/> Legs</p> <p><input type="checkbox"/> Feet</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Hands</p> <p><input type="checkbox"/> Shoulders</p>	<p style="text-align: center;">GASTROINTESTINAL</p> <p><input type="checkbox"/> Appetite Poor</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Bowel Changes</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Excessive Hunger</p> <p><input type="checkbox"/> Excessive Thirst</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Rectal Bleeding</p> <p><input type="checkbox"/> Stomach Pain</p> <p><input type="checkbox"/> Vomiting no blood</p> <p><input type="checkbox"/> Vomiting bleeding</p>	<p style="text-align: center;">ENDOCRINE</p> <p><input type="checkbox"/> Weight Gain</p> <p><input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Heat Intolerance</p> <p><input type="checkbox"/> Cold Intolerance</p> <p><input type="checkbox"/> Breast Changes</p> <p><input type="checkbox"/> Hair C Changes</p> <p><input type="checkbox"/> Extreme Thirst</p>
<p style="text-align: center;">MEN ONLY</p> <p><input type="checkbox"/> Breast Lumps</p> <p><input type="checkbox"/> Erection Difficulties</p> <p><input type="checkbox"/> Lump in Testicles</p> <p><input type="checkbox"/> Penis Discharge</p> <p><input type="checkbox"/> Sore on Penis</p> <p><input type="checkbox"/> Other _____</p>	<p style="text-align: center;">PSYCHIATRIC</p> <p><input type="checkbox"/> Hyperventilation</p> <p><input type="checkbox"/> Insecurity</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Trouble Sleeping</p> <p><input type="checkbox"/> Irritable</p> <p><input type="checkbox"/> Anxiousness</p> <p><input type="checkbox"/> Indecisiveness</p> <p><input type="checkbox"/> Timid</p> <p><input type="checkbox"/> Hallucinations</p> <p><input type="checkbox"/> Loss of Memory</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Drug Addiction</p> <p><input type="checkbox"/> Drug Dependency</p> <p><input type="checkbox"/> Extreme Worry</p> <p><input type="checkbox"/> Sexual Problems</p> <p><input type="checkbox"/> Suicidal Thoughts</p>	<p style="text-align: center;">GENITO-URINARY</p> <p><input type="checkbox"/> Painful Urination</p> <p><input type="checkbox"/> Lack of Bladder Control</p> <p><input type="checkbox"/> Frequent Urination</p> <p><input type="checkbox"/> Blood in Urine</p>	
<p>MEDICATIONS (list any medications you are taking, and dosages)</p> <p>_____</p> <p>_____</p> <p>_____</p>		<p>ALLERGIES to medications or substances</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>PATIENT SIGNATURE (or guardian) _____</p>		<p>Date _____</p>	

Gladden Hunter Chiropractic Corp.
990 Enchanted Way, Suite 101A
Simi Valley, CA 93065
805.520.2929

Patient Information Form

As you read through and fill out these questions please understand that this is an application to Dr. Gladden's Proprietary Pain Relief Program. This is NOT a guarantee of acceptance. Dr. Gladden will be assessing your case and analyzing it for 5 criteria which she will review with you. This Program is only for patients with severe/chronic back pain, herniated discs, bulging discs, spinal stenosis, and sciatica. Dr. Gladden **ONLY** works with patients who are tired of, or who don't want to take medications, those who want an alternative to dangerous injections, invasive surgeries, or have had failed back surgeries. If you are not serious about finding a solution to your problem please be respectful of her time and she will do the same for you.

Today's Date _____
Name _____ Age _____ Birthday _____ Sex M F
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Best Place To Reach You (circle one) Home / Work / Cell Email Address: _____
Employer _____ Occupation _____ Length of Employ _____
Marital Status S M W D Spouses Name _____ SS# _____

I (signature) _____ consent to allow Dr. Gladden to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for non-surgical spinal decompression and also to determine if she is willing to accept my case. It is also my understanding that the consultation is at no charge.

How Did You Hear About Our Office? _____
How Serious Do You Think Your Problem Is? _____
In Reference To The Severity How Would You Rate it On A Scale Of 0-10 _____

What Is Your Reason For Prompting Your Request For A Consultation With The Doctor?

How Do You View Your Problem (circle one).... MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitations)
SEVERE (Causing Significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

1. In spite of the fact that you are not a back specialist, you are in fact the person who knows more about your back than anyone else. In your own words and in your own opinion what do you think the real problem is?

2. What are you hoping happens today as a result of the doctor spending time with you today?

3. Since your back pain became this severe what three things has it caused you to miss the most?

4. How long have you been like this?

5. What changes/modifications have you had to make and how has your lifestyle change since your back problem?

6. What actions or activities do you have troubles with or are have limitations in?

7. What kinds of treatments have you received?

Surgeries:	How Many _____	Approx Date _____	
Injections:	How Long _____	Approx Date _____	How Long _____
Drugs/Pharmaceuticals:	_____	Approx Date _____	How Long _____
Physical Therapy:		Approx Date _____	How Long _____
Other	_____		

8. When did you receive these treatments and for how long?

9. Did any of these treatments seem to work in helping your pain? If so which one(s)? For how long?

10. What actions can you take that temporarily decrease the pain?

11. What activities/movements are guaranteed to increase your pain and worsen your condition?

12. What does the pain feel like (Sharp, Dull, achy, toothache, shooting, stabbing, numb, tingling, etc...) and where?

13. What does it feel like when you wake up compared to the rest of the day? Is it worse in the morning or the evening?

14. What do you think will happen to you if you cannot find a solution to your pain/problem?

15. What are you hoping Dr. Gladden tells you today?

16. Please express what you hope or imagine his state of the art program and knowledge might be able to accomplish for you?

17. Describe what will be different in your life if you can get better.

18. Please describe in detail the VERY FIRST time you recall having this problem and what it felt like?

List In Order Of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above.

1. _____ How Long? _____
2. _____ How Long? _____
3. _____ How Long? _____
4. _____ How Long? _____

What percentage of time are you aware of your main problem? (circle one)

- Occasionally (25% of the time)
- Intermittently (50% of the time)
- Frequently (75% of the time)
- Constant (90-100% of the time)

Due To Your Main Problem.....

- Have You Lost Any Time From Work? Yes No
- How Much Time and What Have You been unable to perform? _____
- Have You Lost Any Time From Your Obligations At Home? Yes No
- How Much Time and What Tasks Have Been Limited? _____
- Have You Lost Any Time From Your Family? Yes No
- How Much Time and What Tasks Have Been Limited? _____
- Have You Lost Any Time From Enjoying Your Leisure Activities? (Hobbies, Travel, Sports, etc...)
- How Much Time and What Tasks Have Been Limited? _____
- Considering the amount of pain/discomfort you've had THIS week, how long has your problem been this severe?
- _____

On a Scale of 0-10 (10 being unbearable, 0 being No Pain or Discomfort) Please rate the following...

- The HIGHEST your pain gets WITHOUT medication _____
- The LOWEST your pain gets WITHOUT medication _____
- The HIGHEST your pain gets WITH medication _____
- The LOWEST your pain gets WITH medication _____
- List ANY surgeries that you have had and the corresponding dates.
- _____
- _____