Office Use ONLY	#
Demographics and Photo	
Day 0	
Day 1	
Welcome Video	
BROF Video	

Confidential Patient Health Record

Date: _____

Name_____ Date of Birth _____ Age _____

Address_____City_____ State_____ Zip_____

SS#_____-_____-_____ Male / Female Email Address _____

Home #_____ Cell #_____

Occupation_____ Employer_____ Work # _____

Employer's Address_____

City_____ State_____ Zip Code_____

Marital Status_____ Spouse's Name_____

Spouse's Occupation_____ Spouse's DOB_____

How Many Children Do You Have?_____ Children's Ages_____

Emergency Contact Name_____ Phone #_____

Whom May We Thank For Referring You To Our Office? _____

Name and location of Primary Care Physician? _____

What Medications Are You Currently Taking?_____

_____

What Surgeries Have You Had? _____

_____

List Any Accidents Or Falls_____

Date and Location of Most Recent X-Rays? _____

Date of Most Recent Bloodwork? _____

PRIMARY HEALTH CONCERN

What Is Your Primary Health Concern? _____

How Long Have You Been Experiencing This Problem?_____

On A Scale of 1 to 10, How Severe Is It at Its Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

What Makes it Feel Better?_____ Feel Worse?_____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen by Another Doctor ☐Never Received Treatment for This Problem

SECONDARY HEALTH CONCERN

What Is Your Primary Health Concern? _____

How Long Have You Been Experiencing This Problem?_____

On A Scale of 1 to 10, How Severe Is It at Its Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

What Makes it Feel Better?_____ Feel Worse?_____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen by Another Doctor ☐Never Received Treatment for This Problem

ADDITIONAL HEALTH CONCERN

What Is Your Primary Health Concern? _____

How Long Have You Been Experiencing This Problem?_____

On A Scale Of 1 To 10, How Severe Is It at Its Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

What Makes it Feel Better?_____ Feel Worse?_____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen by Another Doctor ☐Never Received Treatment for This Problem

ADDITIONAL HEALTH CONCERN

What Is Your Secondary Health Concern? _____

How Long Have You Been Experiencing This Problem?_____

On A Scale of 1 to 10, How Severe Is It at Its Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

What Makes it Feel Better?_____ Feel Worse?_____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen by Another Doctor ☐Never Received Treatment for This Problem

Please check to indicate if you are currently or have ever experienced any of the following:

- ❑ Alcoholism
- ❑ Allergies
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Ankle Swelling
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arm/Hand Pain
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain/Stiffness
- ❑ Bleeding Disorders
- ❑ Blurred Vision
- ❑ Bowel/Bladder Changes
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependence
- ❑ Chest Pain
- ❑ Chicken Pox
- ❑ Cold Feet/Hands
- ❑ Cold Sores
- ❑ Cold Sweats
- ❑ Constipation
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Fatigue
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Hair Loss
- ❑ Headaches
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herniated Disc
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Jaw Problems
- ❑ Kidney Disease
- ❑ Leg/Knee Pain
- ❑ Light Bothers Eyes
- ❑ Liver Disease
- ❑ Loss of Memory
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Low Body Temp
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Nausea
- ❑ Neck Pain/Stiffness
- ❑ Nervousness
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pinched Nerve
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Leg
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus
- ❑ Skin Rashes
- ❑ Sleeping Difficulties
- ❑ Stomach Problems
- ❑ Strep Throat
- ❑ Stroke
- ❑ Sudden Weight Loss
- ❑ Suicide Attempt
- ❑ Tension
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tubes in Ears
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other _____

Is There A Family History of Any of The Following Conditions? (Indicate Family Member Including Parents, Grandparents & Siblings)

❑ Arthritis _____
❑ Autoimmune _____
❑ Cancer _____
❑ Diabetes _____
❑ Heart Disease _____
❑ Neurological Diseases_____
❑ Other _____

Received A Diagnosis for ANY Condition by Another Health Care Provider? Y N

If Yes, What Was the Diagnosis?

_____

Who Provided the Diagnosis?_____

Medication Name	Dosage	Reason

Supplement Name/Brand	Dosage	Reason

Please list any allergies: _____

Lifestyle History

Do You Exercise?
❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Does Your Work Activity Mostly Involve?
❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What Is Your Daily/Weekly Intake of The Following?
Caffeine _____ Cups/Day Alcohol ___ Drinks/Week
Cigarettes ____Packs/Day
Have You Ever Been Exposed to Mold? Yes _____ No _____
Have You Ever Been Exposed to Chemicals (Work, Pesticides, Etc.)? Yes _____ No ____

Sleep/Rest:

Average Number of Hours You Sleep: _____ More Than 10 _____ 8 To 10 _____ 6 To 8 _____ Less Than 6

Do You Have Trouble Sleeping? Yes_____ No _____

Do You Have Problems Falling Asleep? Yes_____ No _____

Do You Have Problems Staying Asleep? Yes_____ No _____

Do You Feel Rested Upon Awakening? Yes_____ No_____

Do You Have Problems with Insomnia? Yes _____ No _____

Do You Snore? Yes_____ No _____

Do You Use Sleeping Aids? Yes _____ No _____

Dental History:

Do You Have (Or Had) Any Non-Tooth Colored Fillings (I.e. Silver or Gold Colored Fillings)?

Yes _____ No _____ How Many _____

Have You Had Any Fillings Removed? Yes _____ No _____

Do You Have Any Root Canals? Yes _____ No _____ How Many? _____

Other Dental Fixtures? Yes_____ No_____ Describe_____

Have You Had Any Dental Work in The Last 12 Months? Please Describe.

_____

_____

_____

_____

Is There Anything Else You Would Like Our Providers to Know?

I Certify That the Above Questions Were Answered Accurately. I Understand That Providing Incorrect Information Can Be Dangerous to My Health.

SIGNATURE (X) _____ DATE _____

Advanced Health and Wellness Center

What are your life goals and where do you see yourself in the next 10 to 20 years?

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____