Wei Institute Doctor's Name ________________________________ Date _______________ File #:

PATIENT HEALTH HISTORY **Re-evaluation:** [ ]Yes

1. Name: ______________________________ Gender: [ ]M, [ ]F Age: _________ Height: _______ Weight: ______
   Address: ____
   Phone: ____________________ E-mail: ______________________________________ Birthday: ____________
   *Wei Institute Doctor's Name: _________________________ Phone: _____________Fax:_________________
   *Wei Institute Doctor's Name Email: ____
   * Required information – without it your treatment recommendation will be delayed or not processed
2. What is your chief complaint? (Describe your condition at its worst)
   ____
   ____
   Other Complaints: ____
   Diagnosed Medical Conditions: ____

3. Please Describe Symptoms of Your Lung Condition:

Symptom Severity	(10 is the worst)
Shortness of Breath	
Wheezing	
Coughing	
Chest Tightness	
Excessive Phlegm	
Color of phlegm	
Energy Level (10 is the best)	
Distance walked in 6 min (meters)	

Oxygen Use

None	
All the Time	
Exercise	
Sleep	
Volume (Liters/min)	
Color of phlegm	
Hours of O2 use a day	
Oxygen Saturation Level	
Time to Reach O2 Saturation (min, sec)	

Activities That Make You Breathless

Strenuous Exercise	
Walking up Hill	
1 mile/After 15 min	
100 yards/ Few min of walking	
Anything	

Measurements and Medications

FEV1	
Lung Capacity (%)	
Inhalers (Time/day)	
Prednisone (mg/day)	
Diuretics (i.e. Lasix)	

4. What treatments have you tried? ____
5. Please list any current therapies: ____
6. List vitamins or supplements taken in the last 2 months: ____
7. List prescribed and over-the-counter pharmaceutical medication taken in the last 2 months:
   ____
   ____
   ____
8. If you are currently under the care of a health care practitioner for any conditions or injuries, please provide their:
   Name: _______________________________ Phone: __________________ Email: _________________________
   Description of Treatment: ____

9. Please describe your health history (please check).

Now Past

___ ___ Acid Reflux/Heart Burn
___ ___ AIDS/HIV
___ ___ Alcoholism
___ ___ Allergies
___ ___ Anemia
___ ___ Appendicitis
___ ___ Arthritis
___ ___ Arteriosclerosis
___ ___ Asthma
___ ___ Atrial Fibrillation
___ ___ Birth Trauma
___ ___ Bronchiectasis
___ ___ Breast Lump
___ ___ Cancer
___ ___ Candida
___ ___ Chicken Pox
___ ___ Chronic Bronchitis
___ ___ Chronic kidney disease
___ ___ Cirrhosis
___ ___ Congestive heart failure
___ ___ COPD

Now Past

___ ___ Coronary artery disease
___ ___ Cystic Fibrosis
___ ___ Diabetes
___ ___ Diverticulitis
___ ___ Drug Withdrawal
___ ___ Emphysema
___ ___ Epilepsy
___ ___ Eczema
___ ___ Erectile Dysfunction
___ ___ Fatty Liver
___ ___ Fibromyalgia
___ ___ Fibroid
___ ___ Gall Bladder Stone
___ ___ Goiter
___ ___ Gout
___ ___ Hernia
___ ___ Heart Murmur
___ ___ Hepatitis
___ ___ Herpes
___ ___ High Blood Pressure
___ ___ High Cholesterol

Now Past

___ ___ Hyperlipidemia
___ ___ Influenza
___ ___ IBD
___ ___ IBS
___ ___ Kidney Stone
___ ___ Kidney Failure
___ ___ Lyme Disease
___ ___ Meniere's Disease
___ ___ Mental Disorder
___ ___ Migraines
___ ___ Multiple Sclerosis
___ ___ Ovarian Cyst
___ ___ Pacemaker
___ ___ Pancreatitis
___ ___ Pleurisy
___ ___ Pneumonia
___ ___ Prostatitis
___ ___ Psoriatic arthritis
___ ___ Psoriasis
___ ___ Pulmonary fibrosis
___ ___ Rheumatic Fever

Now Past

___ ___ Rheumatoid Arthritis
___ ___ Sarcoidosis
___ ___ Scoliosis
___ ___ Scarlet Fever
___ ___ Small intestine bacteria overgrowth (SIBO)
___ ___ Seizures
___ ___ Stroke
___ ___ Thyroid Disorders
___ ___ Tuberculosis
___ ___ Typhoid Fever
___ ___ Ulcers, Location: _________
___ ___ Ulcerative Colitis
___ ___ Crohn's Disease
___ ___ UTI
___ ___ Interstitial Cystitis
___ ___ Vitiligo
___ ___ Venereal Disease
___ ___ Whooping Cough
___ ___ Other, Describe ___________

10. Please use the point scales to rate your symptoms over the past 3 months.

1 = Occasional, Not Severe 2 = Occasional, Severe 3 = Frequent, Not Severe 4 = Frequent, Severe

Digestive Tract
___Acid reflux/heart burn
___Poor Digestion
___Nausea & Vomiting
___Bloating
___Gas
___Hiccups
___Bad Breath
___Gluten Intolerance
___Food Allergies
___Chemical Sensitivities
___Malnutrition
___Difficulty Swallow
___Diarrhea
___Constipation
___Laxative Use
___Blood in Stool
___Mucous in Stool
___Black Stool
___Stomach Pains/Cramps
___Abdominal Pain
___Abdominal Spasms
___Lack of Bowel Control
___Itchy Anus
___Rectal Pain
___Hemorrhoids
___Anal Fissures
Bowel Movements:
Frequency____________
Color________________
Texture/Form__________
Odor_________________

General
___Sweat Easily
___Night Sweats
___Gall Bladder Troubles
___Cold Hands or Feet
___Poor Circulation
___Spitting Blood
___Fever
___Chills
___Muscle Cramps
___Lower Extremity Edema
___Vertigo or Dizziness
___Bleed or Bruise Easily
___Frequent Illness
___Seasonal Allergy
___Addicted to Drugs
___Addicted to Smoking
___Peculiar Taste:
Describe: ___________

Respiratory
___Tight Ches
___Shortness of Breath
___Difficulty Breathing When Lying Down
___Itching Inside the Chest
___Wheezing
___Persistent Cough
___Coughing Blood
___Cough: Wet / Dry, Thick / Thin
Color of Phlegm____________
___Other Lung Problems

Urinary
___Bedwetting
___Blood in Urine
___Lack of Bladder Control
___Pain During Urination
___Frequent/urgent urination
___Incomplete Urination
___Wake to Urination
___Prostate Problem
___Genital Itch or Discharge
___Premature Ejaculation
___Recurrent Bladder Infections
___Impotence
___Increased Libido
___Decreased Libido

Weight & Eating
___Recent Weight Loss
___Recent Weight Gain
___Binge Eating/
___Binge Drinking
___Craving Certain Foods
Describe: __________
___Excessive Weight
___Loss of Taste
___Compulsive Eating
___Poor Appetite
___Heavy Appetite
___Strongly Like Cold Drinks
___Strongly Like Hot Drinks
___Water Retention

Musculoskeletal
___Muscle Pains
___Muscle Cramps
___Pains or Aches in Joints
___Stiffness/Limited Range of Motion
___Pains or Aches in Muscles
___Feeling of Weakness/Tiredness
___Swollen Tender Joints
___Growing Pains in Legs
___Hip Tightness/Coldness/Pain
___Rib Pain
___Neck/Shoulder Pain
___Upper Back Pain
___Back Pain
___Lower Back Pain
___Sciatic Pain

Cardiovascular
___Heart Murmur
___Heart Palpitations
___Irregular or Skipped Heartbeat
___Rapid or Pounding Heartbeat
___Chest Pain
___Difficulty Breathing
___High Blood Pressure
___Low Blood Pressure
___Blood Clots
___Anemia
___Fainting
___Tachycardia

Emotions
___Mood Swings
___Anxious, Fear, Nervous
___Angry Irritable, Aggressive
___Easily Stressed
___Argumentative
___Frustrated, Cries Easily
___Depression
___Abuse Survivor
___Considered/Attempted Suicide
___Seeing a Therapist
___Obsessive Behavior
___Compulsive Thoughts
___Uncontrollable Urges

Mind
___Poor Memory
___Difficulty Completing Projects
___Difficulty with Mathematics
___Underachiever
___Poor/Short Attention Span
___Confusion
___Easily Distracted
___Difficulty Making Decisions
___Learning Disability

Neurological
___Seizures
___Numbness
___Tics
___Foot Neuropathy

Energy & Activity
___Apathy, Lethargy
___Attention Deficit
___Fatigue
___Lack of Strength
___Body Heaviness
___Hyperactivity
___Restlessness
___Shortness of Breath

___Stuttering or Stammering
___Slurred Speech

Ears
___Itchy Ears
___Ear Aches, Ear Infections
___Drainage from Ears
___Hearing Loss
___Reddening of the Ears
___Ringing in the Ears
___Headaches
___Concussions

Nose
___Stuffy Nose
___Dryness Inside the Nose
___Chronic Red/Inflamed Nose
___Sinus Problem
___Hay Fever
___Sneezing Attacks
___Excessive Mucous Formation
___Back Dripping
___Nose Bleeding

Eyes
___Glasses/Contacts
___Watery or Itchy Eyes
___Red, Swollen/Sticky Eyelids
___Bags/Dark Circle under Eyes
___Poor Vision
___Blurred or Tunnel Vision
___Sensitive to Sunlight

___Eye Strain
___Eye Pain
___Red Eye
___Itchy Eyes
___Easily Fatigued Eye
___Spots in Eyes
___Night Blindness
___Glaucoma
___Cataract

Head
___Headaches
___Migraines
___Faintness
___Dizziness
___Facial Flushing
___Facial Pain
___TMJ

Sleep
___Insomnia
___Sleep Disorder
___Difficulty to Fall Asleep
___Difficulty to Stay Asleep
___Frequently Wakes Up
___Morning Shakness
___Cannot Wake Up in Morning

Mouth & Throat
___Chronic Coughing
___Gagging, Often Clearing Throat
___Sore Throat, Hoarse, Voice Loss
___Swollen/Discolored Tongue/Lips
___Sores on Lips or Tongue
___Canker Sores
___Itching on Roof of Mouth
___Dry Mouth
___Excessive Saliva
___Recurrent Sore Throat
___Excessive Phlegm
Color: ____________
___Swollen Glands
___Lumps in Throat
___Enlarged Thyroid
___Teeth Problem
___Gum Problem
___Grinding Teeth

Skin & Hair
___Acne
___Itching
___Hives
___Rash
___Eczema
___Dry Skin
___Ulcerations
___Hair Loss
___Dandruff
___Flushing or Hot Flashes
___Change in Hair/Skin Texture
___Loss in Pigmentation
___Skin Fungal Infections

For Women Only
Age Menstrual Cycle Began:
____
Length of Cycle (Day 1 - Day 1):
____
Duration of Flow: _________
___Dark Color Flow
___Clots in Flow
___Excessive Flow
___Irregular Circle
___Painful Period
Painful Intercouse
___Excessive Vaginal Discharge
___Menopause Symptoms
___Lump in Breast
___Vaginal Dryness
___Vaginal Sores
___Vaginal Odor
Vaginal Discharge Color:
____
# of Pregnancies: _______
# of Live Births: ________
# of Premature Births: ____
Age at Menopause: ______
Date Last Period Began:
____

Any Other Symptoms:
____
____
____

11. Operations and Procedures

Date		Date		Date		
_________	Tonsillectomy	__________	Appendectomy	_________	Hernia	**Other:** _______________
_________	Gall Bladder	__________	Female Organs	_________	Thyroid	**Date:** ______________
_________	Back Operation	__________	Rectal Surgery	_________	Stomach	
_________	Tubes in Ears	__________	Sinus	_________	Heart	

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The heath care provider's office will prepare necessary paperwork to assist me in the filling insurance claims but cannot guarantee reimbursement. All services rendered to me are my personal responsibility and I agree to make payments for these services to the health care provider's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable.
I authorize the health care provider to examine and treat my condition as deemed appropriate through the use of chiropractic care, acupuncture, Traditional Chinese Medicine, and/or other natural healing methods.

Patient's / Guardian's Signature: ___________________________________ Date: _______________

Please fax it to: 217-213-5094. You can also scan and e-mail it to info@pro-activewellness.com or mail it to: Proactive Wellness, 1207 East Main Strret, Danville IL 61832