New Tripoli Whole Health
Treating the Individual, Not the Symptom.

Health History

Patient Name: Date: **Please print ALL information and SIGN BELOW**

Present Condition

What is the reason for this visit:	When did it start:	How often do you feel this way ☐constant ☐occasional ☐intermittent
Are you getting: ☐better ☐worse ☐same	Have you had this before? ☐Yes ☐No	Does it interfere with: ☐work ☐sleep ☐daily routine ☐recreation
If you have pain, is it: ☐Sharp ☐Throb ☐Dull ☐Ache ☐Burn ☐Tingle ☐Stiff ☐Cramp ☐Other		Rate it on a scale of 1(least) to 10(severe):
What have you tried: ☐chiropractic ☐medicine ☐physical therapy ☐surgery ☐none ☐other		What helped:
Is there anything else you would like to tell us about?		How long has it been since you felt great?

Health History

Are you pregnant: ☐yes ☐no Due date? Last menstrual Period?

Date of last:
Physical exam: X-ray: MRI/CT: Blood Work: Urinalysis:

Please List All Past Injuries & Surgeries:	Description	Date(s)
Fractures		
Dislocations		
Surgeries		
Other		

Have you had:

☐Acid reflux	☐Chronic Fatigue	☐Gout	☐Knee pain	☐Parkinson's	☐Stroke
☐AIDS/HIV	☐Diabetes	☐Hand pain	☐Leg pain	☐Pinched nerve	☐Thyroid disorder
☐Anemia	☐Digestive problem	☐Heart problem	☐Liver disease	☐PMS	☐Tonsillitis
☐Arm pain	☐Dizziness	☐Hernia	☐Low blood sugar	☐Prostate problem	☐Tuberculosis
☐Arthritis	☐Eczema	☐Herniated disc	☐Measles	☐Psychiatric care	☐Typhoid fever
☐Asthma	☐Epilepsy	☐High BP	☐Migraines	☐Respiratory disease	☐Ulcer
☐Bleeding	☐Eye problem	☐Hip pain	☐Mumps	☐Rheumatic fever	☐Venereal disease
☐Cancer	☐Fibromyalgia	☐Hot flashes	☐Mononucleosis	☐Scarlet fever	☐Whooping cough
☐Carpal tunnel	☐Foot pain	☐Infertility	☐Osteoporosis	☐Scoliosis	☐Other
☐Chicken Pox	☐Gall bladder issue	☐Kidney disease	☐Polio	☐Sexual dysfunction	

Do you have a family history of:
☐Heart Disease ☐Diabetes ☐Cancer ☐Stroke ☐Kidney Disease ☐Liver Disease ☐Osteoporosis ☐Thyroid Problems

How frequently do you urinate: Day: Night:	How often do you have a bowel movement: ☐daily ☐every other day ☐every three days ☐weekly

Exercise:	Sleep:	Water:	Work activity:	Habits:	
☐daily	☐3-4 hours	☐2-3 glasses	☐sit	☐smoke	packs/day
☐weekly	☐5-7 hours	☐4-7 glasses	☐stand	☐alcohol	drinks/wk
☐rarely	☐8-10 hours	☐8-10 glasses	☐light labor	☐caffeine	cups/day
			☐heavy labor	☐high stress	

List all Medications:	List all Allergies:	List all Vitamins/Herbs/Supplements:

Print Patient's Name Sign Patient's Name Date