Health Profile

Back to Natural Health

Robert Selig, D.C.
1937 W. Diversey Pkwy #C1-E
Chicago, IL 60614

(773) 325-BACK(2225)
Fax (773) 477-6567

Date:_____

Homeopathic and Chiropractic consultations are facilitated when there is a complete history of the person's mental, emotional, and physical state of health. Please assist me by providing the answers to the following health and medical history questions.

Contact and Birth Information

Name_____ Age_____ Sex_____
Birth Date _____ Birth Time _____ Place of Birth_____
Address_____
City_____ State _____Country _____Zip Code_____
Phone (home)_____ (work)_____ (cell)_____
E-mail_____

Married____ Separated____ Divorced____ Widowed____ Single____ Cohabitating____
Live with: Spouse____ Lover____ Parents____ Relatives____ Friends____ Alone____
Other____
Pets (list)_____

What type of education do you have?_____
What profession or type of work do you do?_____
Occupation _____Full or Part Time _____Retired_____
Employer: _____
Military Service:
Where did you serve?_____
When did you serve?_____
Did you get injuries, vaccinations or treatments of any kind?_____
_____
_____

Referred by:_____

Homeopathy and Chiropractic Therapy:

Are you familiar with, or have you ever had Homeopathic or Chiropractic Therapies?

_____

Your Chief Complaints

In your opinion, what are your most important health problems? List as many as you can in order of importance:

1)_____ 5)_____
2)_____ 6)_____
3)_____ 7)_____
4)_____ 8)_____

Comments about your most important health problems:

_____
_____
_____
_____
_____

Your General Health

On a scale of 1-10, how do you rate your health now?_____
The general state of my health has been: Excellent_____ Good_____ Fair____ Poor____
How is your general vitality, stamina, and energy?_____
Are you a warm or chilly person?_____
Are you a thirsty person?_____ Do you prefer warm or cold drinks?_____

Your Health History

When did your complaint or ailment begin?_____
_____
_____
_____

What do you think causes or has caused your aliment or complaint?_____
_____
_____

Have you had an experience (traumatic or otherwise) that did or still does affect you deeply? Explain. _____
_____
_____

What childhood illnesses have you had?

Disease	When	Disease	When
Rubella (3 day measles)	_____	Mumps	_____
Measles (two week)	_____	Chickenpox	_____
Whooping Cough	_____	Asthma	_____
Scarlet Fever	_____	Polio	_____
Rheumatic Fever	_____	Others_____	_____

If you have had any of the following tests or immunizations, place an (X) on the appropriate line. If you can, give the year you last had them:

Year	Tests	Year	Immunizations
_____	Chest X-ray	_____	Smallpox
_____	Kidney X-ray	_____	Tetanus
_____	G.I. Series	_____	Polio
_____	Colon X-ray	_____	Typhoid
_____	Gallbladder X-ray	_____	Flu
_____	Electrocardiogram	_____	Mumps
_____	T.B. Test	_____	Measles
_____	Other X-rays	_____	Rubella
_____		_____	Diphtheria
_____		_____	Other

Hospitalizations: (list as best you can)

Type of illness/operation	Date	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Now	Past	Never		Now	Past	Never	
____	____	____	Allergies	____	____	____	Emphysema
____	____	____	Anemia	____	____	____	Heart Condition
____	____	____	Arthritis	____	____	____	Kidney Disease
____	____	____	Gout	____	____	____	Liver Disease
____	____	____	Hepatitis	____	____	____	Obesity
____	____	____	Anorexia	____	____	____	Bulimia
____	____	____	Asthma	____	____	____	High Blood Pressure
____	____	____	Bleeding	____	____	____	Injury (serious)
____	____	____	Bruising	____	____	____	Pneumonia
____	____	____	Cancer	____	____	____	Rheumatism
____	____	____	Tumors	____	____	____	Thyroid Trouble
____	____	____	Colitis	____	____	____	Tuberculosis
____	____	____	Convulsions	____	____	____	Epilepsy
____	____	____	Mental Disease	____	____	____	Ulcers

____ ____ ____ Depression ____ ____ ____ Migraine Headache
____ ____ ____ Diabetes ____ ____ ____ Drinking
____ ____ ____ Drugs ____ ____ ____ Herpes
____ ____ ____ Eczema ____ ____ ____ AIDS
____ ____ ____ Sexually Transmitted Diseases (STD's) Venereal- Gonorrhea, Syphilis, other)

Which STD's and when:_____
_____
_____

Which of these do you use:

Yes	**Amount**	**Yes**	**Amount**
____ Coffee	_____	____ Birth Control	_____
____ Cigarettes	_____	____ Sedatives	_____
____ Alcohol	_____	____ Tranquilizers	_____
____ Aspirin	_____	____ Thyroid	_____
____ Other Drugs	_____	____ Laxatives	_____
____ Electric Blanket	_____	____ Cortisone	_____
____ Herbs and Teas	_____	____ Hormones	_____
____ Recreational Drugs	_____	____ Vitamins	_____
____ Other Therapies	_____		

Are you allergic to any drugs?_____
_____
Are you allergic to any foods or other substances?_____
_____
What happens when you have an allergic attack or reaction?_____
_____
_____

Family Health History

If deceased, list the cause of death and age at death.

Relation	**Living**	**Deceased**	**Cause**	**Age**
Your Mother	___	___	_____	____
Your Father	___	___	_____	____
Your Brother(s)	___	___	_____	____
	___	___	_____	____
Your Sister(s)	___	___	_____	____
	___	___	_____	____

Mother's Side

Your Grandfather ___ ___ _____ ____
Your Grandmother ___ ___ _____ ____

Father's Side

Your Grandfather ___ ___ _____ ____
Your Grandmother ___ ___ _____ ____

Has any blood relative had any of the following?

Yes	No	Unknown		Yes	No	Unknown	
___	___	___	Allergies	___	___	___	Hay Fever
___	___	___	Anemia	___	___	___	Heart Attack
___	___	___	Arthritis	___	___	___	High Blood Pressure
___	___	___	Asthma	___	___	___	Seizure or Epilepsy
___	___	___	Bleeding	___	___	___	Sickle Cell Anemia
___	___	___	Cancer	___	___	___	Stroke
___	___	___	Diabetes	___	___	___	Thyroid Trouble
___	___	___	Depression	___	___	___	Tuberculosis
___	___	___	Eczema	___	___	___	Venereal Disease
___	___	___	Glaucoma	___	___	___	Gout

General Symptoms: Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you now or in the past.

<u>Musculoskeletal System</u>

Now	Past		Now	Past	
(Neck)					
____	____	stiffness	____	____	whiplash
____	____	pain, swelling	____	____	injuries
____	____	radiating pain			
(Middle Back)					
____	____	stiff, painful	____	____	injuries
____	____	herniated disc(s)	____	____	radiating pain
____	____	arthritis			
(Low Back, Sacrum)					
____	____	stiff, painful lower back	____	____	arthritis
____	____	radiating pain	____	____	injuries
____	____	herniated disc(s)			

(Limbs)
____ ____ joint pain, swelling, stiffness, tingling, numbness; Where?_____
____ ____ muscles cramps
____ ____burning of soles of feet
____ ____ unusual redness of the palms or hands
____ ____ arthritis; Where?_____ What kind?_____
____ ____ injuries; Where?_____

Cardiovascular System

Now	**Past**		**Now**	**Past**	
____	____	chest pain when walking	____	____	leg vain problems
____	____	ankle swelling	____	____	leg pain when walking
____	____	high blood pressure	____	____	shortness of breath
____	____	heart palpitations			

Endocrine System

Now	**Past**		**Now**	**Past**	
____	____	excessive hair	____	____	prefer cold weather
____	____	cold hands or feet	____	____	unexplained weight gain/loss
____	____	prefer hot weather	____	____	increased thirst
____	____	weakness	____	____	increased hunger
____	____	can't stand cold	____	____	can't stand heat
____	____	chronic fatigue	____	____	excess sweating

Sleep and Dreams
Do you have any history of sleep problems or irregular sleep patterns? _____
_____
_____
Sleepy during the day?_____ When?_____

Do you usually dream? _____ Do you remember your dreams?_____
Any recurring themes?_____
_____
_____
_____

Now	**Past**		**Now**	**Past**	
____	____	insomnia	____	____	nightmares/bad dreams
____	____	wakes unrefreshed	____	____	too hot or cold during sleep
____	____	sleep deprivation	____	____	night sweats

Blood, Lymph, Immune Systems

Now	Past		Now	Past	
____	____	swollen lymph nodes	____	____	chronic fatigue
____	____	wounds heal slowly	____	____	fevers or chills
____	____	difficulty stopping bleeding	____	____	blood transfusions
____	____	anemia, tires easily	____	____	re-occurring infections
____	____	bleeding from unusual places	____	____	bruises easily
____	____	swollen glands	____	____	unexplained illness

Respiratory System

Now	Past		Now	Past	
____	____	unexplained coughs	____	____	chest pain when breathing
____	____	mucus in lungs	____	____	shortness of breath
____	____	wheezing, asthma	____	____	chronic cough
____	____	difficulty breathing	____	____	lung infections
____	____	difficulty breathing at night	____	____	tobacco smoking

How far can you walk or how many stairs can you climb without having to stop?_____

_____

What makes you stop?_____

Nervous System

Now	Past		Now	Past	
____	____	loss of balance	____	____	paralysis
____	____	convulsions, seizures	____	____	lack of strength
____	____	tremors	____	____	numbness
____	____	involuntary movement	____	____	nerve pain

Skin and Hair

Now	Past		Now	Past	
____	____	rough, dry, scaly, bumpy, itchy	____	____	acne
____	____	moles	____	____	boils, abscess
____	____	cysts	____	____	oily skin
____	____	dry, cracked skin	____	____	hair loss
____	____	light or dark patches	____	____	eczema
____	____	increased hair growth	____	____	dermatitis
____	____	age spots	____	____	sensitive skin
____	____	color changes in nails	____	____	wrinkles, premature
____	____	hives, rashes	____	____	blackheads, clogged pores
____	____	infections	____	____	scars, keloids
____	____	ridges, pits or spots on nails	____	____	warts

Digestive System

Now	Past		Now	Past	

____ ____ acid reflux
____ ____ blood in stool
____ ____ constipation
____ ____ change in bowel movements
____ ____ black or white stools
____ ____ heartburn
____ ____ excess belching
____ ____ stomach pain and aches
____ ____ distress from fats or greasy foods
____ ____ foul stools, undigested food
____ ____ bad breath, bad taste in mouth
____ ____ indigestion after meals
____ ____ heavy, full feeling after eating
____ ____ excessive lower bowel gas
____ ____ stomach pain 5-6 hours after eating
____ ____ foul body odor
____ ____ sudden weight loss
____ ____ sudden weight gain
____ ____ nervous, shaky, headaches; relieved by eating
____ ____ irritability related to missing meals
____ ____ sudden, strong cravings
____ ____ waking up hungry at night
____ ____ injury

____ ____ vomiting, nausea
____ ____ diarrhea
____ ____ fissures
____ ____ anal itching
____ ____ vomiting blood
____ ____ gas and bloating
____ ____ jaundice
____ ____ painful swallowing
____ ____ worms, parasites
____ ____ colitis
____ ____ surgeries, injuries
____ ____ poor assimilation
____ ____ weight gain or loss
____ ____ food allergies
____ ____ special diets
____ ____ overweight
____ ____ loss of appetite
____ ____ infection

How often do you have bowel movements?_____
Do you strain?_____
What does your diet consist of?_____
_____
_____
How frequently do you eat?_____
Who prepares your food?_____
Do you snack? On what?_____
_____
What food(s), condiments(s), or any other substances (i.e. tobacco, alcohol, coffee) do you crave?_____
_____
Are you repelled by or do you dislike any foods? Please identify them. _____
_____

Urogenital System

Now Past

____ ____ frequent urination
____ ____ night urination
____ ____ trouble holding

Now Past

____ ____ painful urination
____ ____ trouble starting urine
____ ____ blood in urine

Male Problems

Now	Past		Now	Past	
____	____	prostate problems	____	____	difficulty with ejaculation
____	____	discharge from penis	____	____	lumps or swelling in testicles
____	____	erectile dysfunction	____	____	infection
____	____	painful erection	____	____	infertility
____	____	injury			

What contraception do you use? _____

Female Problems

Now	Past		Now	Past	
____	____	discharge from vagina	____	____	spotting between periods
____	____	difficulty feeling aroused	____	____	infection
____	____	no lubrication when aroused	____	____	infertility
____	____	never or seldom orgasm	____	____	menstrual flow is absent
____	____	sex is painful	____	____	menstrual flow is excessive
____	____	pain before period	____	____	pain during period
____	____	pain after period	____	____	lumps in breast

Do you have premenstrual symptoms like cramping, water retention, breast tenderness, headaches, depression, or irritability? Please describe.

_____
_____
_____

Menses

Period every ____ days. Regular? Yes No
Period usually lasts ____ days.
Average flow is…. Light Medium Heavy
Date of last period: _____
Number of Pregnancies: _____
Number of Births: _____
Nursed Children:_____
Trouble with lactation?_____
Number of Miscarriages:_____ Date(s):_____
Number of Abortions:_____ Date(s):_____
Any complaints during pregnancy? Yes No
If yes, please list:_____
_____
How old were you when you started having menstrual periods? _____
Do you have any nipple discharge? Yes No
What form of contraception do you use?_____
_____

General Symptoms

Now	Past		Now	Past	
(Hair)					
____	____	dandruff	____	____	damage from treatments
____	____	hair loss	____	____	dry hair
____	____	baldness	____	____	oily hair
(Head)					
____	____	dizziness	____	____	migraines
____	____	severe headaches	____	____	fainting spells
____	____	seizures or fits	____	____	nerve pains
____	____	head injuries	____	____	facial paralysis
(Eyes)					
____	____	infections	____	____	bloodshot eyes
____	____	light hurts eyes	____	____	blurry vision
____	____	double vision	____	____	weak vision
____	____	glaucoma	____	____	eyestrain
____	____	poor eyesight (near or far-sighted)	____	____	injuries
(Ears)					
____	____	discharge from ears	____	____	ear infections
____	____	pain in ears	____	____	injuries
____	____	hearing troubles	____	____	ringing in ears
____	____	excessive earwax	____	____	deafness
(Nose)					
____	____	nosebleeds	____	____	sensitive smell
____	____	mucus, nasal congestion	____	____	loss of smell
____	____	sinus problems	____	____	post nasal drip
____	____	difficulty breathing through nose	____	____	injuries
(Mouth)					
____	____	sore mouth or tongue	____	____	discolored/brittle teeth
____	____	speech difficulties	____	____	mouth sores/ulcers
____	____	loss of teeth	____	____	tooth aches
____	____	gum bleeding	____	____	receding gums
____	____	gum infections	____	____	cavities

Now	Past		Now	Past	
(Throat)					
____	____	hoarseness	____	____	soreness
____	____	difficulty swallowing	____	____	chocking
____	____	loss of voice	____	____	sores/ulcers
____	____	laryngitis	____	____	swelling
____	____	mucus	____	____	sensitivity

Mental and Emotional

Now	Past		Now	Past	
____	____	anxiety	____	____	feel better from exercise
____	____	fears or phobias	____	____	lack of motivation
____	____	nervousness, restlessness	____	____	mental fatigue
____	____	poor self confidence	____	____	insomnia
____	____	memory trouble	____	____	trouble concentrating
____	____	anger or irritability	____	____	crying spells
____	____	feeling of worthlessness	____	____	depression
____	____	trouble getting along w/others	____	____	suicidal thoughts
____	____	mood swings	____	____	easily upset or disappointed
____	____	obsessive behaviors	____	____	loss of emotional control
____	____	brain fog	____	____	panic attacks
____	____	fear of public speaking	____	____	history of being abused
____	____	put yourself last	____	____	emotional shocks, trauma
____	____	see things others don't	____	____	suppressed anger or grief
____	____	hear voices	____	____	alcohol or drug addictions
____	____	think others want to hurt you	____	____	deep grief
____	____	trouble dealing with stress	____	____	excess stress
____	____	late for appointments	____	____	timid

Do you have peculiar sensations? _____

If yes, what and where?_____

_____

Additional Comments: Is there anything you wish to add? Also use the back of the page if necessary.

_____

_____

_____

_____

_____

_____

How would you like to improve your health? (i.e. skin, hair, weight, teeth, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
_____
_____

Are you presently on any of these treatments?

Yes	**Amount**	**Yes**	**Amount**
___ Oil Pulling	_____	___ Detox Baths	_____
___ Herbal Teas/Tinctures	_____	___ Foot Baths	_____
___ Chiropractic Treatments	_____	___ Homeopathic Remedies	_____
___ Oil Massages	_____	___ Homeopathic Cell Salts	_____
___ Foot Oil Massages	_____	___ Natural Cosmetics	_____
___ Breast Massages	_____	___ Colonics/Enemas	_____
___ Testes Tapping	_____	___ Lucid Dream Therapy	_____
___ Qigong/Tai-Chi/Yoga	_____	___ Inhalation Therapy	_____
___ Qigong Self Massage	_____	___ Tonics	_____
___ Standing Meditations	_____	___ Other Therapies	_____

Are you having any problems with the therapy or therapies you are doing? _____
If yes, what?_____
_____
_____
_____

Have you noticed changes in your general health since you started the therapy (specific health problems, sleep, vitality, mental and emotional state, etc.)?_____
_____
_____
_____
_____
_____