

Wei Institute Practitioner Name \_\_\_\_\_ Date \_\_\_\_\_ File #:

**PATIENT HEALTH HISTORY** **Re-evaluation: \_\_\_Yes**

1. Name: \_\_\_\_\_ Gender: [ ]M [ ]F Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 E-mail: \_\_\_\_\_  
 Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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)	
Hours of O2 use a day	
Oxygen Saturation Level	
Time to Reach O2 Saturation (min, sec)	

**Activities That Make You Short of Breath**

Strenuous Exercise	
Walking uphill/ stairs	
1 mile/After 15 min	
100 yards/ Few min of walking	
Anything/ Daily Activities	

**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 or over-the-counter pharmaceutical medication taken in the last 2 months and corresponding dosage:

\_\_\_\_\_

8. Do you have, or have you ever had (please check):

Avascular Necrosis	Chondromalacia Patellar Syndrome	Joint Separations	Post-herpetic neuralgia
Bone Spurs	DDD	Meniscus Tear	Sprains
Bulging Disc	Ganglion/Baker's Cyst	Morton's Neuroma	Stenosis
Bursitis	Herniated Disc	Non-union Fracture	Tendonitis
Cartilage injury	Intercostal Neuralgia	Osteoarthritis	

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

Now	Past	Now	Past
		Acid Reflux/Heart Burn	Hyperlipidemia
		AIDS/HIV	Influenza
		Alcoholism	IBD
		Allergies	IBS
		Anemia	Kidney Stones
		Appendicitis	Kidney Failure
		Arthritis	Lyme Disease
		Arteriosclerosis	Meniere's Disease
		Asthma	Mental Disorder
		Atrial Fibrillation	Migraines
		Birth Trauma	Multiple Sclerosis
		Bronchiectasis	Ovarian Cyst
		Breast Lump	Pacemaker
		Cancer, Location:	Pancreatitis
		Candida	Pleurisy
		Chicken Pox	Pneumonia
		Chronic Bronchitis	Prostatitis
		Chronic kidney disease	Psoriatic arthritis
		Cirrhosis	Psoriasis
		Congestive heart failure	Pulmonary fibrosis
		COPD	Rheumatic Fever
		Coronary artery disease	Rheumatoid Arthritis
		Cystic Fibrosis	Sarcoidosis
		Diabetes	Scoliosis
		Diverticulitis	Scarlet Fever
		Drug Withdrawal	Small intestine bacteria overgrowth (SIBO)
		Emphysema	Seizures
		Epilepsy	Stroke
		Eczema	Thyroid Disorders
		Erectile Dysfunction	Tuberculosis
		Fatty Liver	Typhoid Fever
		Fibromyalgia	Ulcers, Location:
		Fibroid	Ulcerative Colitis
		Gall Bladder Stones	Crohn's Disease
		Goiter	UTI
		Gout	Interstitial Cystitis
		Hernia	Vitiligo
		Heart Murmur	Venereal Disease
		Hepatitis	Whooping Cough
		Herpes	Other, Describe
		High Blood Pressure	
		High Cholesterol	

10. Please rate your symptoms over the past 3 months: (1 = None, 2 = Light, 3 = Moderate, 4 = Severe)

Rate	<b>Digestive Tract</b>	Rate	<b>Urinary</b>
	Acid Reflux/Heart Burn		Bedwetting
	Poor Digestion		Blood in Urine
	Nausea & Vomiting		Lack of Bladder Control
	Bloating		Pain During Urination
	Gas		Frequent/Urgent Urination
	Hiccups		Incomplete Urination
	Bad Breath		Wake to Urinate
	Gluten Intolerance		Prostate Problems
	Food Allergies		Genital Itch or Discharge
	Chemical Sensitivities		Premature Ejaculation
	Malnutrition		Recurrent Bladder Infections
	Difficulty Swallowing		Impotence
	Diarrhea		Increased Libido
	Constipation		Decreased Libido
	Laxative Use		
	Blood in stool		<b>Weight &amp; Eating</b>
	Mucous in Stool		Recent Weight Loss
	Stomach Pains/Cramps		Recent Weight Gain
	Abdominal Pain		Binge Eating
	Abdominal Spasms		Binge Drinking
	Lack of Bowel Control		Craving Certain Foods
	Itchy Anus		Describe
	Rectal Pain		Excessive Weight
	Hemorrhoids		Loss of Taste
	Anal Fissures		Compulsive Eating
	Bowel Movements:		Poor Appetite
	Frequency		Heavy Appetite
	Color		Strongly Like Cold Drinks
	Texture/Form		Strongly Like Hot Drinks
	Odor		Water Retention

	<b>General</b>		<b>Eyes</b>
	Sweat Easily		Glasses/Contacts
	Night Sweats		Watery/Itchy Eyes
	Cold Hands/Feet		Red/Swollen/Sticky Eyelids
	Poor Circulation		Bags/Dark Circles Under Eyes
	Spitting Blood		Poor Vision
	Fever		Blurred/Tunnel Vision
	Chills		Sensitive to Sunlight
	Muscle Cramps		Eye Strain
	Lower Extremity Edema		Eye Pain
	Vertigo/Dizziness		Red Eyes
	Bleed/Bruise Easily		Itchy Eyes
	Frequent Illness		Easily Fatigued Eyes
	Season Allergy		Spots in Eyes
	Addicted to Drugs		Night Blindness
	Addicted to Smoking		Glaucoma
	Peculiar Taste:		Cataracts
	Describe:		

	<b>Energy &amp; Activity</b>		<b>Respiratory</b>
	Apathy/Lethargy		Tight Chest
	Attention Deficit		Shortness of Breath
	Fatigue		Difficulty Breathing When Lying Down
	Lack of Strength		Itching Inside the Chest
	Body Heaviness		Wheezing
	Hyperactivity		Persistent Cough
	Restlessness		Coughing Up Blood
	Shortness of Breath		Cough (Wet/Dry/Thick/Thin)
	Stuttering/Stammering		Color of Phlegm
	Slurred Speech		Other Lung Problems

Please rate your symptoms over the past 3 months: (1 = None, 2 = Light, 3 = Moderate, 4 = Severe)

Rate	<b>Musculoskeletal</b>	Rate	<b>Emotions</b>
	Muscle Pains		Mood Swings
	Muscle Cramps		Anxious/Fear/Nervous
	Pains/Aches in Joints		Angry Irritable
	Stiffness/Limited Range of Motion		Aggressive
	Pains/Aches in Muscles		Easily Stressed
	Feeling of Weakness/Tiredness		Argumentative
	Swollen/Tender Joints		Frustrated/Cries Easily
	Pain in Legs		Depression
	Hip Tightness/Coldness/Pain		Abuse Survivor
	Rib Pain		Suicidal
	Neck/Shoulder Pain		Seeing a Therapist
	Upper Back Pain		Obsessive Behavior
	Back Pain, General		Compulsive Thoughts
	Lower Back Pain		Uncontrollable Urges
	Sciatic Pain		

	<b>Mind</b>		<b>Nose</b>
	Poor Memory		Stuffy Nose
	Difficulty Completing Projects		Dryness Inside Nose
	Difficulty with Simple Math		Chronic Red/Inflamed Nose
	Underachiever		Sinus Problems
	Poor/Short Attention Span		Hay Fever
	Confusion		Sneezing Attacks
	Easily Distracted		Excessive Mucous
	Difficulty Making Decisions		Back Dripping
	Learning Disability		Nose Bleeds

	<b>Cardiovascular</b>		<b>Skin &amp; Hair</b>
	Heart Murmur		Acne
	Heart Palpitations		Itching
	Irregular/Skipping Heartbeat		Hives
	Rapid/Pounding Heartbeat		Rash
	Chest Pain		Eczema
	Difficulty Breathing		Dry Skin
	High Blood Pressure		Ulcerations
	Low Blood Pressure		Hair Loss
	Blood Clots		Dandruff
	Anemia		Flushing/Hot Flashes
	Fainting		Change in Hair/Skin Texture
	Tachycardia		Loss in Pigmentation
			Skin Fungal Infections

	<b>Ears</b>		<b>Head</b>		<b>Neurological</b>
	Itchy Ears		Headaches		Seizures
	Ear Aches/Infections		Migraines		Numbness
	Drainage from Ears		Dizziness		Tics
	Hearing Loss		Facial Flushing		Foot Neuropathy
	Reddening of the Ears		Facial Pain		
	Ringling in the Ears		TMJ/TMD		
	Headaches				
	Concussions				

Please rate your symptoms over the past 3 months: (1 = None, 2 = Light, 3 = Moderate, 4 = Severe)

Rate	<b>Sleep</b>	Rate	<b>For Women Only</b>
	Sleep Disorder		Age Menstrual Cycle Began
	Difficulty Falling Asleep		Length of Cycle (# of Days)
	Difficulty Staying Asleep		Length of Flow (# of Days)
	Waking Up Frequently		Dark Color Flow
	Morning Shakiness		Cots in Flow
	Cannot Wake Up in the Morning		Excessive Flow
			Irregular Cycle
	<b>Mouth &amp; Throat</b>		Painful Period
	Chronic Coughing		Painful Intercourse
	Gagging/Often Clearing of Throat		Excessive Vaginal Discharge
	Sore Throat/Hoarse/Voice Loss		Menopause Symptoms
	Swollen/Discolored Tongue/Lips		Lump(s) in Breast
	Sores on Lips/Tongue		Vaginal Dryness
	Canker Sores		Vaginal Sores
	Itching on Roof of Mouth		Vaginal Odor
	Dry Mouth		Color of Vaginal Discharge
	Recurrent Sore Throat		# of Pregnancies
	Excessive Phlegm		# of Live Births
	Color:		# of Premature Births
	Swollen Glands		Age at Menopause
	Lumps in Throat		Date of Last Period
	Enlarged Thyroid		Date of Last PAP Test
	Teeth Problems		Any Other Symptoms:
	Gums Problems		
	Grinding Teeth		

### 11. Operations and Procedures

Date		Date		Date		Date	Other
	Tonsillectomy		Appendectomy		Hernia		
	Gall Bladder		Gynecological		Thyroid		
	Back		Rectal		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 health care provider's office will prepare necessary paperwork to assist me in the filing 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: 408-844-9450. You can also scan and e-mail it to [info@weiinstitute.com](mailto:info@weiinstitute.com)  
 Or mail it to: Wei Institute, 2880 Zanker Road, Ste. 205, San Jose, CA 95070