

## **Well Rooted Lung Health & Wellness**

16 Madison Square West, 11th Floor  
New York, NY 10010

Dear Patient:

Thank you for your visit today. In order to provide you with holistic care and address the root cause of your health concerns, we would like you to complete a detailed and comprehensive health questionnaire. Your answers will help you achieve better treatment results. The more you are willing to share with us, the better we can treat the root cause of your health conditions and symptoms.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Referred By \_\_\_\_\_ Date \_\_\_\_\_ File #: \_\_\_\_\_

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

1. Name: \_\_\_\_\_ Gender: [ ]M, [ ]F Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Email \_\_\_\_\_

\*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. Have you ever used: [ ]Chiropractic Treatment [ ]Chinese Herbal Medicine [ ]Acupuncture [ ]Homeopathy  
 If yes, for which conditions? \_\_\_\_\_

If no, would you like to hear about options for your condition (please circle)? Yes No

3. What is the reason for your visit? What is your chief complaint? (Describe your condition at its worst)  
 \_\_\_\_\_  
 \_\_\_\_\_

Other Complaints: \_\_\_\_\_

Diagnosed Medical Conditions: \_\_\_\_\_

4. Cause of Health Conditions: [ ] Injury [ ] Auto Accident [ ] Personal Injury [ ] Other: \_\_\_\_\_

Has the accident been reported? Yes No Reported to: [ ]Employer [ ]Auto Carrier [ ]Other: \_\_\_\_\_

Are you now or have you ever been disabled? Yes No Date: \_\_\_\_\_ Cause: \_\_\_\_\_

Have you ever retained an attorney? Yes No Name: \_\_\_\_\_ Phone: \_\_\_\_\_

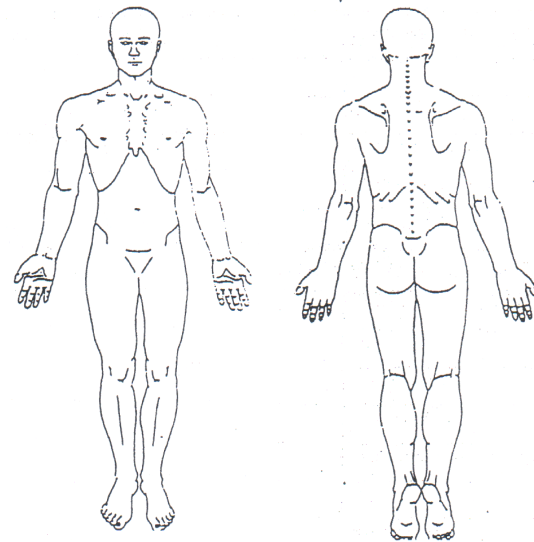
5. Pain Symptoms: a. \_\_\_\_\_ Began (Mo/Yr) \_\_\_\_\_ Previous Episodes (Mo/Yr) \_\_\_\_\_  
 (In Order b. \_\_\_\_\_ Began (Mo/Yr) \_\_\_\_\_ Previous Episodes (Mo/Yr) \_\_\_\_\_  
 of Severity) c. \_\_\_\_\_ Began (Mo/Yr) \_\_\_\_\_ Previous Episodes (Mo/Yr) \_\_\_\_\_

6. Please circle areas of pain or discomfort and mark them using the codes listed below:

N=Numbness, T=Tingling, B=Burning, P=Pain, S=Soreness, A=Ache, SB=Stabbing, SF=Stiffness, X=Scars

List the frequency and severity of your condition on a scale of 1 to 5:

Frequency:	Severity:
1=20% of the time	1=Annoying
2=40% of the time	2=Impairment to Activity
3=60% of the time	3=Need Medication
4=80% of the time	4=Impairment with Medication
5=100% of the time	5=Severe (Need Hospitalization)



Location	Frequency	Severity	Initial Cause	Getting Worse?	
a. _____	_____	_____	_____	Yes	No
b. _____	_____	_____	_____	Yes	No
c. _____	_____	_____	_____	Yes	No

Does it affect other areas of your body (please circle)? Yes No  
 If yes, explain: \_\_\_\_\_

7. Do you have, or have you ever had:  
 Osteoarthritis \_\_\_ Bone Spurs \_\_\_ Non-union Fracture \_\_\_  
 Bulging Disc \_\_\_ Tendonitis \_\_\_ Avascular Necrosis \_\_\_  
 Herniated Disc \_\_\_ Joint Separations \_\_\_ Post-herpetic neuralgia \_\_\_  
 DDD \_\_\_ Bursitis \_\_\_ Intercostal Neuralgia \_\_\_  
 Stenosis \_\_\_ Sprains \_\_\_ Morton's Neuroma \_\_\_  
 Cartilage injury \_\_\_  
 (Meniscus Tear, Chondromalacia  
 Patellar Syndrome)

8. Does the condition interfere with (please circle): Work Sleep Other: \_\_\_\_\_  
 Please describe: \_\_\_\_\_

Without treatment, how would it affect your quality of life? \_\_\_\_\_  
 \_\_\_\_\_



- 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 Trouble
- 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 Chest
- 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 Urinate
- 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/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
- Pain 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 Skipping 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
- Chronically 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 or Sticky Eyelids
- Bags/Dark Circles Under Eyes
- Poor Vision
- Blurred or Tunnel Vision
- Sensitive to Sunlight
- Eye Strain
- Eye Pain
- Red Eyes
- Itchy Eyes
- Easily Fatigued Eyes
- Spots in Eyes
- Night Blindness
- Glaucoma
- Cataract

**Head**

- Headaches
- Migraines
- Faintness
- Dizziness
- Facial Flushing
- Facial Pain
- TMJ

**Sleep**

- Insomnia
- Sleep Disorder
- Difficulty Falling Asleep
- Difficulty Staying Asleep

- Wakes Up Frequently
- Morning Shakiness
- 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 Cycle
- Painful Period
- Painful Intercourse
- 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:**

- \_\_\_\_\_
- \_\_\_\_\_

17. Operations and Procedures

<b>Date</b>		<b>Date</b>		<b>Date</b>		<b>Other:</b>	_____
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus	<b>Date:</b>	_____
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia		
_____	Gall Bladder	_____	Gynecological	_____	Thyroid		
_____	Back Operation	_____	Rectal Surgery	_____	Stomach		

List and date any accidents or falls (please check):

Car \_\_\_\_\_,  Recreation \_\_\_\_\_,  Sports \_\_\_\_\_,  School \_\_\_\_\_,  Other \_\_\_\_\_

List any broken bones: \_\_\_\_\_

Have you ever had spinal taps or spinal injections (please circle)?      Yes      No      Date: \_\_\_\_\_

Have you ever lost consciousness (please circle)?      Yes      No      Why? \_\_\_\_\_

Have you ever had X-ray taken?      Yes      No      Date: \_\_\_\_\_ By Whom? \_\_\_\_\_

For what ailment were these X-rays taken? \_\_\_\_\_

Do you suffer from any condition other than that for which you are now consulting us? \_\_\_\_\_

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 filling insurance claims but cannot guarantee reimbursement. Direct payments made from the insurance company to the health care provider's office will be credited to my account upon receipt and any balances due will be my responsibility. 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. Should third party collection become necessary, I agree to pay all fees involved in collections of the account.

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:** \_\_\_\_\_