Wright Health Centre
New Client History

Name _________________________________ Day/Night/Cell Phone ______________________ __
Parent/Guardian's signature if client is younger than 16 years old___________________________
Address _______________________________City _________________Postal code ___________ __
Date of Birth D_____M_____Y_____ Age ___Sex ___Occupation ________________________ __
Marital Status ❒M ❒S ❒D ❒W **E-mail address**: __________________________________
Alternative phone #: _________________________________Referred by: ___________________
Today's date: _____________Family doctor: _______________________Phone: _____________

FAMILY HISTORY

❒Diabetes ❒Cancer ❒Allergies ❒Mental illness

PERSONAL HISTORY

Check off all that currently apply:

❒Smoke cigarettes How many______/day
❒Drink alcohol How many _____/day
❒Drink coffee How many _____/day
❒Recreational drugs Type ______________ How often _______________
❒Exercise How many times ______/week
❒Pacemaker
❒Pregnant now
❒Mercury or silver fillings in your teeth How many ________
❒Titanium implants, staples or metal plates
❒Prednisone or steroid
❒Anaphylactic reactions (an allergic reaction that causes the throat to swell making it difficult or impossible to breathe)
❒Severe allergy, if yes, what substance?____
❒Known allergies/ ____
❒Recent vaccinations ____
❒Never been vaccinated
❒Problems or complications from vaccines

CURRENT MEDICATIONS (Please list)

____

MAIN COMPLAINTS

____

____

____

WHAT TYPES OF TREATMENTS HAVE YOU TRIED?

____

____

MEDICAL HISTORY

List illnesses and accidents: ____
____
____

Check only those that apply:

Please rate each symptom on a scale of 1-10. One means the symptom is hardly noticeable, 10 means the symptom in intolerable.

___❒Acid reflux
___❒Addictions: ___________________
___❒Anemia
___❒Arthritis
___❒Asthma
___❒Bad breath
___❒Bags under the eyes
___❒Blood pressure problems
___❒Bowel disorders
___❒Brain fog, can't think clearly
___❒Breast pain/swelling
___❒Burning feet
___❒Burning/itching anus
___❒Canker sores
___❒Colitis
___❒Congestion
___❒Constipation
___❒Cough
___❒Cradle cap
___❒Cravings _____________________
___❒Dark circles around the eyes
___❒Diarrhea
___❒Fatigue
___❒Fears/Phobias
___❒Frequent colds and flus
___❒Fungus
___❒Hair falling out
___❒Headaches
___❒Heartburn/indigestion
___❒Hyperactivity
___❒Irritable
___❒Itching, general
___❒Itchy, watery eyes
___❒Lump in the throat
___❒Memory issues
___❒Menstrual problems ___________
___❒Mood swings
___❒Muscle cramps/spasms
___❒Numbness
___❒Pain in the heels
___❒Pains that move around
___❒Peeling skin
___❒Post nasal drip
___❒Psoriasis
___❒Rashes, describe _______________
___❒Restlessness
___❒Seizures
___❒Sensitive to weather changes
___❒Sexually transmitted disease
___❒Shortness of breath
___❒Sinusitis
___❒Sneezing
___❒Sore throat
___❒Swelling
___❒Tightness in the chest
___❒Tingling
___❒Trembling internally
___❒Trouble learning
___❒Urinary tract infections
___❒Vomiting, frequent
___❒Yeast infections
___❒Daily energy level 1/10

Other symptoms, physical/emotional trauma

____
____
____
____
____
____
____
____
____
____
____
____