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 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 Blood Type: ❒O ❒ A ❒B ❒AB
❒Pregnant now
❒Mercury or silver fillings in your teeth How many _____
❒Titanium implants, staples or metal plates or root canals
❒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 _____
❒Pets at home, please circle: Dogs Cats Birds Other
❒Recent/Covid vaccinations _____
❒Never been vaccinated
❒Problems or complications from vaccines:_____

CURRENT MEDICATIONS (Please list)

_____

MAIN COMPLAINTS

_____

_____

MEDICAL HISTORY

List illnesses and accidents: _____
_____
_____

What food items do you think you react to? _____

Check only those that apply:
Please rate each symptom on a scale of 0-10. 1 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
___❒Breast pain/swelling
___❒Burning feet
___❒Burning/itching anus
___❒Can't think clearly
___❒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
___❒Hyperactivity
___❒Indigestion
___❒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

Other symptoms:

_____
_____
_____
_____
_____
_____