Dr. Jess E. Bethel

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402-452-3414 **FAX**

www.midwesthealthne.com

CONFIDENTIAL HEALTH INFORMATION

All information you provide is confidential.
We comply with all federal privacy standards.
Please print clearly.

MIDWEST
NATURAL WELLNESS CENTER

_____
Today's Date (MM/DD/YYYY)

How did you hear about our office?

___Google ___Social Media ___Internet Ad ___Mailer/E-mail

___ Other ___Someone You Know
If other, please explain:
_____

If so, whom?_____

Have you consulted a chiropractor before?

☐ No ☐ Yes **When?** _____ &

If so, whom?

Biological Sex:

___ Male
___ Female

XXX-XX-_____
Last 4 digits of your SSN

_____
Your Last Name

_____
Your First Name

_____
Birth Date (MM/DD/YYYY)

Marital Status

☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

_____
Address

_____ _____ _____
City **State/Province** **Zip/Postal Code**

_____ _____
Home Phone **Spouse's Name**

_____
Email Address

_____ _____
Cell Phone **Child's Name & Age**

_____
Emergency Contact **Relationship To You**

_____ _____
Emergency Contact Phone Number **Child's Name & Age**

_____
Your Occupation

_____
Your Employer

_____
Work Address

_____ _____
Child's Name & Age

May we contact you at work?

☐ Yes ☐ No

Preferred method of contact:

☐ Home Phone ☐ Cell Phone
☐ Work Phone ☐ Email

_____ _____ _____
City **State/Province** **Zip/Postal Code**

_____
Work Phone

Please be prepared to show your driver's license to the front desk staff so that a copy can be made and added to your patient file.

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ☐ An accident or injury ☐ Work ☐ Auto ☐ A worsening long-term issue

☐ An Interest In: ☐ Wellness ☐ Other: _____

3. **Onset** (When did you first notice your current symptoms)?

_____

4. **Intensity** (how extreme are your current symptoms)?

0 ☐☐☐☐☐☐☐☐☐☐ 10

Absent Uncomfortable Agonizing

5. **Duration and Timing** (When did it start and how often do you feel it)?

☐ Constant ☐ Comes and goes. How often? _____

_____

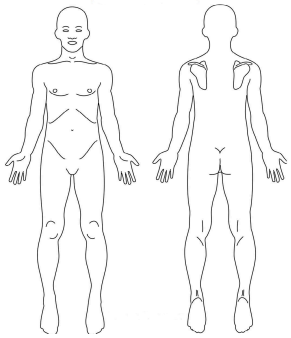
6. **Quality of Symptoms** (what does it feel like)?

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramps
- ☐ Nagging
- ☐ Sharp
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing
- ☐ Other:

_____

7. **Location** (Where does it hurt)? Circle the area(s) on the illustration.

☐ = current condition ✕ = conditions experienced in the past



8. **Radiation** (Does it affect other areas of your body, and to what areas does the pain radiate, shoot or travel)?

_____

9. **Aggravating or Relieving Factors** (What makes it better or worse, such as: time of day, movements, certain activities, etc.)?

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. **Prior Interventions** (What have you done to relieve the symptoms)?

- ☐ Homeopathic Remedies
- ☐ Over-the-counter Drugs
- ☐ Physical Therapy
- ☐ Prescription Medication
- ☐ Surgery
- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Massage
- ☐ Ice
- ☐ Heat
- ☐ Other _____

11. What else should Dr. Bethel know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or Career: _____

Recreational Activities: _____

Household Responsibilities: _____

Personal Relationships: _____

13. **Review of Systems**

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **HAD** or currently **HAVE** and initial to the right.

a. **Musculoskeletal**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck Pain	☐	☐	Back Problems	☐	☐	Hip Disorders
☐	☐	Knee Injuries	☐	☐	Foot/Ankle Pain	☐	☐	Shoulder Problems	☐	☐	Elbow / Wrist Pain	☐	☐	TMJ Issues	☐	☐	Poor Posture

NONE ☐ Initials_____

b. **Neurological**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Headache	☐	☐	Dizziness	☐	☐	Pins & Needles	☐	☐	Numbness

NONE ☐ Initials_____

c. **Cardiovascular**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	High Blood Pressure	☐	☐	Low Blood Pressure	☐	☐	High Cholesterol	☐	☐	Poor Circulation	☐	☐	Angina	☐	☐	Excessive Bruising

NONE ☐ Initials_____

d. **Respiratory**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Asthma	☐	☐	Apnea	☐	☐	Emphysema	☐	☐	Hay Fever	☐	☐	Shortness of Breath	☐	☐	Pneumonia

NONE ☐ Initials_____

e. **Digestive**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anorexia or Bulimia	☐	☐	Ulcer	☐	☐	Food Sensitivities	☐	☐	Heartburn	☐	☐	Constipation	☐	☐	Diarrhea

NONE ☐ Initials_____

f. **Sensory**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Blurred Vision	☐	☐	Ringing in Ears	☐	☐	Hearing Loss	☐	☐	Chronic Ear Infection	☐	☐	Loss of Smell	☐	☐	Loss of Taste

NONE ☐ Initials_____

g. **Integumentary**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Skin Cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne	☐	☐	Hair Loss	☐	☐	Rash

NONE ☐ Initials_____

_____
Doctor's Initials
Dr. Jess E. Bethel

h. **Endocrine**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Thyroid issues	☐	☐	Immune Disorders	☐	☐	Hypoglycemia	☐	☐	Frequent Infections	☐	☐	Swollen Glands	☐	☐	Low Energy

NONE ☐ Initials____

i. **Genitourinary**

		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Kidney Stones	☐	☐	Infertility	☐	☐	Bedwetting	☐	☐	Prostate Issues	☐	☐	Erectile Dysfunction	☐	☐	PMS Symptoms

NONE ☐ Initials____

j. **Constitutional**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Fainting	☐	☐	Low Libido	☐	☐	Poor Appetite	☐	☐	Fatigue	☐	☐	Sudden Weight Loss / Gain (circle one)	☐	☐	Weakness

NONE ☐ Initials____ ☐ All Other Systems Negative

Past Personal, Family and Social History

Please identify your past health history, including: accidents, injuries, illnesses and treatments.
Please complete each section fully.

----------PERSONAL----------

14. Illnesses

Check the illnesses you have **Had** in the past, or **Have** now.

Had	Have		Had	Have	
☐	☐	AIDS	☐	☐	Rheumatic Fever
☐	☐	Alcoholism	☐	☐	Scarlet Fever
☐	☐	Allergies	☐	☐	STD
☐	☐	Arteriosclerosis	☐	☐	Stroke
☐	☐	Cancer	☐	☐	Tuberculosis
☐	☐	Chicken Pox	☐	☐	Typhoid Fever
☐	☐	Diabetes	☐		Other:_____
☐	☐	Epilepsy			_____
☐	☐	Glaucoma			_____
☐	☐	Goiter			_____
☐	☐	Gout			_____
☐	☐	Heart Disease			
☐	☐	Hepatitis			
☐	☐	HIV Positive			
☐	☐	Malaria			
☐	☐	Measles			
☐	☐	Multiple Sclerosis			
☐	☐	Mumps			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ☐ Appendix removal
- ☐ Bypass surgery
- ☐ Cancer
- ☐ Gallbladder removal
- ☐ Elective Surgery:_____
  _____
- ☐ Eye Surgery
- ☐ Hysterectomy
- ☐ Pacemaker
- ☐ Spine_____
  _____
- ☐ Tonsillectomy
- ☐ Vasectomy
- ☐ Other:_____
  _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth Control Pills
☐	☐	Chemotherapy
☐	☐	Chiropractic Care
☐	☐	Dialysis
☐	☐	Herbs
☐	☐	Homeopathy
☐	☐	Hormone Replacement
☐	☐	Inhaler
☐	☐	Massage Therapy
☐	☐	Physical Therapy
☐	☐	Nutritional Supplements:

List: _____
_____

☐ ☐ **Medications** (prescription and over-the-counter)

Please List: _____
_____
_____
_____

17. Injuries

Have you ever...

- ☐ Had a fractured or broken bone
- ☐ Had a spine or nerve disorder
- ☐ Been knocked unconscious
- ☐ Been injured in an accident
- ☐ Used a crutch or other support
- ☐ Used neck or back bracing
- ☐ Received a tattoo
- ☐ Had a body piercing

---FAMILY---

18. Family History

Relative	Age (if living)	State of Health Good	State of Health Poor	Illnesses	Age at Death	Cause of Death Natural	Cause of Death Illness
Mother	_____	☐	☐	_____	_____	☐	☐
Father	_____	☐	☐	_____	_____	☐	☐
Sister 1	_____	☐	☐	_____	_____	☐	☐
Sister 2	_____	☐	☐	_____	_____	☐	☐
Brother 1	_____	☐	☐	_____	_____	☐	☐
Brother 2	_____	☐	☐	_____	_____	☐	☐

19. Are there any other hereditary health issues that you know about?_____
_____

---------SOCIAL---------

20. Social History

Tell Dr. Bethel about your health habits and stress levels.

Alcohol use	☐ Daily	☐ Weekly	How much?
Coffee Use	☐ Daily	☐ Weekly	How much?
Tobacco Use	☐ Daily	☐ Weekly	How much?
Exercising	☐ Daily	☐ Weekly	How much?
Pain Relievers	☐ Daily	☐ Weekly	How much?
Soft Drinks	☐ Daily	☐ Weekly	How much?
Water Intake	☐ Daily	☐ Weekly	How much?

Hobbies:_____
_____

Prayer or Meditation?	☐ Yes	☐ No
Job Pressure / Stress?	☐ Yes	☐ No
Financial Peace?	☐ Yes	☐ No
Vaccinated?	☐ Yes	☐ No
Mercury Fillings?	☐ Yes	☐ No
Recreational Drugs?	☐ Yes	☐ No

_____
Doctor's Initials

Dr. Jess E. Bethel

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising Out of Chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Bending Over	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Using a Computer	☐	☐	☐	☐
Getting In/Out of Car	☐	☐	☐	☐
Driving a Car	☐	☐	☐	☐
Looking Over Shoulder	☐	☐	☐	☐
Caring for Family	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery Shopping	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Lifting Objects	☐	☐	☐	☐
Reaching Overhead	☐	☐	☐	☐
Showering or Bathing	☐	☐	☐	☐
Dressing Myself	☐	☐	☐	☐
Love Life	☐	☐	☐	☐
Getting to Sleep	☐	☐	☐	☐
Staying Asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐

22. What is the major stressor in your life?_____

23. How much sleep do you average per night? _____Hours

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position?_____

26. Describe your typical eating habits: ☐ Skip Breakfast ☐ 2 meals/day ☐ 3 meals/day ☐ Snacking Between Meals

27. What would be the most significant thing that you could do to improve your health?_____

_____

28. In addition to the main reason for your visit today, what additional health goals do you have?_____

_____

Acknowledgements

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials_____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge that I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor, print child's full name:_____

_____
Doctor's Initials

Dr. Jess E. Bethel

_____ _____

Signature (patient or legal guardian) **Date (MM/DD/YYYY)**

MSQ - MEDICAL SYMPTOM / TOXICITY QUESTIONNAIRE

NAME: _____ **DATE:** _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the **past 30 days.**

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching, or passing gas
___ Heartburn
___ Intestinal/Stomach pain

Total _____

EARS

___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Total _____

EMOTIONS

___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability, or aggressiveness
___ Depression

Total _____

ENERGY / ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

Total _____

EYES

___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near-or far-sightedness)

Total _____

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total _____

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

Total _____

JOINTS/MUSCLES

___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness

Total _____

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficulty breathing

Total _____

MIND

___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

Total _____

MOUTH/THROAT

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

Total _____

NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

Total _____

SKIN

___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

Total _____

WEIGHT

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

Total _____

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

Total _____

GRAND TOTAL _____

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