True Health Medical and Wellness Center Ltd.
Jennifer Rockwood D.C.
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847-719-5800 Fax 847-847-1442

Name_____ DOB _____ Today's Date: _____

Parent Name (if under 18);_____ Referred By: _____

What is your main areas of concern? When did this begin? What can you <u>NOT</u> do? What is your goal for treatment?

_____

_____

_____

_____

General Health (including cardiac, respiratory, digestive, immune, reproductive and neurological health)

Age	Event	What happened to you?

Injuries (including Auto Accidents, Falls, Concussions, Bike accidents, Traumatic Events)

Age	Event	What happened to you?

Fractures, Surgeries (include cosmetic and dental surgeries)

Age	Event	What happened to you?

Mental Health Considerations

Age	Issue	How managed?

Vision and Sensory Considerations

Age	Issue	How managed?

Infancy Health (Birth- 5 months) especially respiratory, skeletal or head

Age	Issue	How managed?

Prenatal Development (if you know, it is useful information)

Age	Issue	How managed?

Birth Characteristics: (Describe what you know about your birth. Fast, c-section, breech, long, twin etc.)

_____

_____

_____

Please circle yes or no to the following: I am/ Am not currently

____ I am/ am not currently pregnant.

____ I am/ am not currently under treatment for a neurological, autoimmune condition or cancer

____ I am/am not currently under treatment for a chronic pain condition such as fibromyalgia.

____ I have/ have not had corrective eye surgery for lazy eye or crossed eye.

____ I am/am not currently experiencing issues related to a traumatic brain injury.

____ I am/am not seeing a mental health professional.

Signature: _____ Date: _____