create wellness Chiropractic and Sports Medicine Center

DR. HYUN-JUNG OH, N.D.
737-37 Hannam 2 Dong, Yongsan-gu,
Hannam Building 10F, Seoul, South Korea
http://www.createwellnesscenter.com
Tel. 02-798-1446

GENERAL

Name:	Date: / / (Month / Day / Year)	
Date of Birth: / / (Month / Day / Year)	Age:	Gender: M / F
Nationality:	Ethnicity:	
Address:		
Phone (home):	Phone (work):	
Phone (cell):	Email:	
Marital Status: ❑ Single ❑ Partnership ❑ Married ❑ Separated ❑ Divorced ❑ Widowed		# of Children:
Live with (check all that apply): ❑ Spouse ❑ Partner ❑ Children ❑ Parent(s) ❑ Friend(s) ❑ Alone ❑ Pets		
Occupation:	Working hours per week:	
If you are female, are you pregnant? ❑ Yes ❑ No ❑ Trying to become pregnant		

EMERGENCY CONTACT

Name:	Relationship:
Phone (Home):	Phone (Work/Cell):

OTHER HEALTH CARE PROVIDERS

1.	2.
Phone:	Phone:
Fax:	Fax:
Do you have a regular check-up done by another doctor? ❑ Yes (How often do you get a regular check-up? _____) (Date of the last check-up: _____) ❑ No (When was the last time you saw a doctor and for what reason? _____)	

How did you hear about our clinic?_____

Referred by? _____

Are you insured? ❑ Yes ❑ No If yes, by which company? _____

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CURRENT HEALTH ASSESSMENT

What are your present health concerns? Please list in order of importance to you:

1) _____
2) _____
3) _____
4) _____

List current health conditions that you are being treated for: _____

_____

Please list any prescription medications, over the counter medications, vitamins or other supplements you are *currently* taking:

Name	Dosage	Frequency	For What Symptoms or Conditions	Since when/For how long

Please list any drugs, foods, environmental factors or chemicals you are hypersensitive or allergic to:

_____

How would you rate the followings on a scale of 1 to 10, 10 being the highest:

- Your current state of well-being:
- Your current state of *PHYSICAL* health:
- Your current state of *EMOTIONAL* health:
- Your current state of *MENTAL* health:
- Your current stress level:
  Please identify the major sources of stress in your life: _____

When during the day is your energy the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night

When during the day is your energy the worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night

Do you have pain anywhere in the body? If so, please specify the location:

_____

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MEDICAL HISTORY

Please indicate any health conditions, hospitalizations, surgeries, and injuries you have had other than the diagnoses that are currently treated:

Year Illness, Hospitalization, Surgery or Injury

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____
5) _____ _____

Please list any prescription medications, over the counter medications, vitamins or other supplements you took in the past:

_____
_____
_____

What are the most significant or traumatizing events in the past that might have affected your physical, emotional, mental and/or spiritual part of health (eg. loss of a loved one, discouraged passion, serious car accidents, breaking up, etc)?

_____

Please specify physical and psychological/mental illnesses or conditions in your family

Relationship	Age	Medical Condition (physical, emotional and mental), and/or addiction
Parental Grandmother		
Parental Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Mother		
Father		
Brother(s)		
Sister(s)		

*** Thank you for including naturopathic medicine as part of your health care plan. I will do my best to work with you towards your health and wellbeing. Thank you.*