Chiropractic & Wellness SPECIALISTS

NEW PATIENT APPLICATION

Today's Date:_____

Patient Name: _____ Date of Birth:_____ Age today:_____

Address: _____City: _____ State:_____ Zip: _____

Email: _____ Marital Status: S M D W

Best phone number: _____ Cell ☐ or Landline ☐ Work # _____

I wish to receive appointment notices 24 hours prior by Email ☐ or Text ☐ Cell provider?_____

Occupation: _____Employer: _____ Night worker? Y / N

In case of an emergency, please contact _____ Phone:_____

Relationship of emergency contact person to patient: _____

Were you referred by someone? _____

Internet search used? Insurance directory ☐, Google☐ , Yelp ☐ , Facebook ☐ , Other ☐_____

Your Primary Physician or other practitioners that you see: _____

Purpose of this appointment: Pain management/Injury ☐, Nutritional Consult ☐, Functional Medicine ☐, Free Consultation ☐, Endo-Nasal work ☐, CranialSacral work ☐

Please list your areas of complaint below and then on the next page mark the diagrams using the symbols to their right.

1._____ How long have you had this condition? _____

Prior treatment(s) for this condition? Yes ☐ No ☐ Type of treatment(s) received: _____

Please rate your pain as of now 0 1 2 3 4 5 6 7 8 9 10
No Pain Severe Pain

2._____ How long have you had this condition? _____

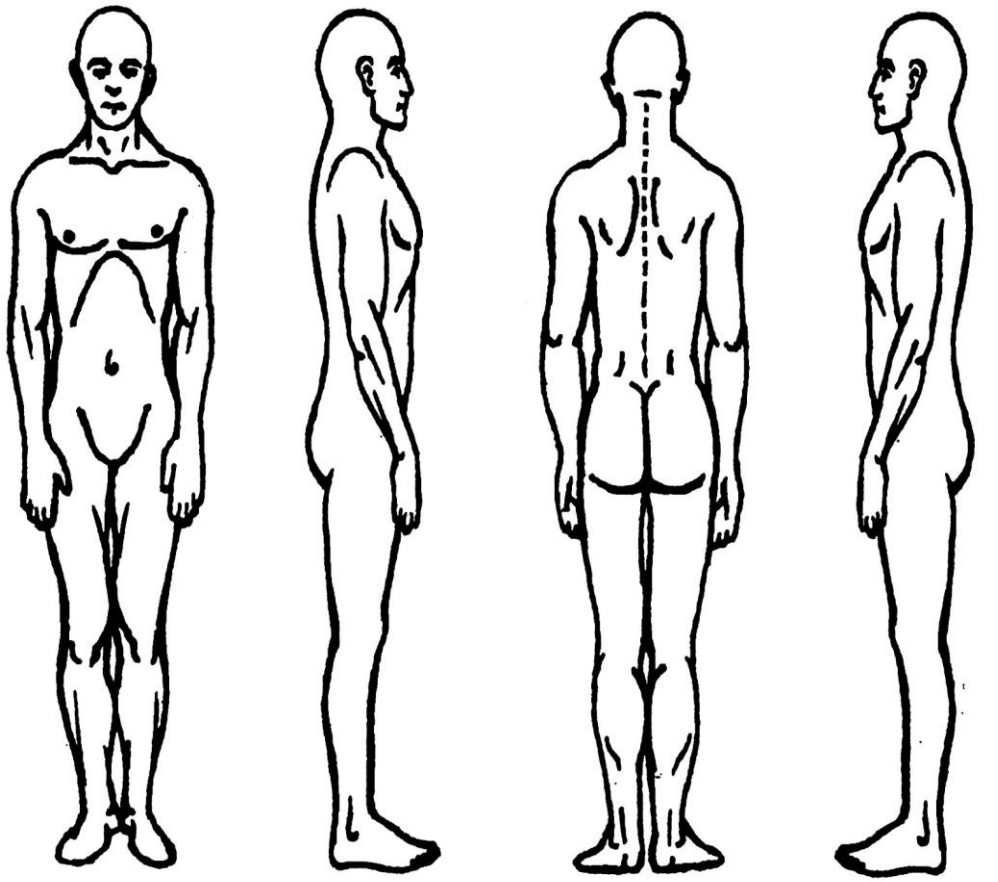
Prior treatment(s) for this condition? Yes ☐ No ☐ Type of treatment(s) received: _____

Please rate your pain as of now 0 1 2 3 4 5 6 7 8 9 10
No Pain Severe Pain

3._____ How long have you had this condition? _____

Prior treatment(s) for this condition? Yes ☐ No ☐ Type of treatment(s) received: _____

Please rate your pain as of now 0 1 2 3 4 5 6 7 8 9 10
No Pain Severe Pain



Aching ^^^
Numbness +++
Pins and Needles OOO
Burning XXX
Stabbing Or Sharp ///

MEDICAL HISTORY: ***Please print clearly and fill in as completely as possible.***

Have you had Chiropractic care in the past? Yes ☐ No☐ If yes, the most recent? _____

Height: _____Weight: _____What is the most you have ever weighed? _____ (BP ____HR___)

List any Current medications, hormones, natural supplements **AND** for what reasons or diagnoses?

1._____ 2._____3._____

4._____ 5._____6._____

List any **allergies** to medications, substances or foods: _____

Have you taken **antibiotics** within the last 5 years? Y / N Years ago? _____

Did you take antibiotics when you were a child? Y / N Details: _____

Have you ever suffered ***TRAUMATIC*** injury?(I.e. Auto wrecks, Horses, Skiing, Snowboarding, etc.) Y / N

1. Year: _____ Age: ____ Details: _____

_____

Were you evaluated and treated? Y / N Successful outcome? Y / N

2. Year:____ Age:____ Details:_____

_____

Were you evaluated and treated? Y / N Successful outcome? Y / N

Any recent ***NON-TRAMATIC*** surgeries, procedures, hospitalization or injuries? Y / N

1. Year: ___ Age ___ Details/Dates: _____

Successful outcome? Y / N

2. Year: ___ Age ___ Details/Dates: _____

Successful outcome? Y / N

Please check all that apply and approximate year of diagnosis and/or resolution. Feel free to elaborate.

__Alcoholism; Sober years? _____
__Alzheimer's Disease
__Anemia; Years? _____
__Asthma
__Autoimmune Diseases: _____
__Bronchitis
__Cancer (type): _____
__Cardiovascular Disease
__Celiac Disease
__Chronic Fatigue Syndrome
__Colitis
__Crohn's Disease
__Depression
__Diabetes; Type 1____ Type 2 ____
__Drug Abuse
__Eating Disorder _____
__Eczema
__Emphysema
__Endometriosis; Surgery/Year? _____
__Epilepsy or Seizures
__Fibromyalgia
__Genetic Disorder: _____
__Glaucoma
__Head Injury (year(s)): _____
__Hepatitis: A B C D

__High Blood Pressure
__High Cholesterol (Statin Drug? Y / N)
__HIV
__Intestinal Parasites
__Irritable Bowel Syndrome
__Kidney Disease
__Leaky Gut Syndrome
__Mental Illness
__Migraine Headaches
__Multiple Sclerosis
__Mononucleosis
__Osteoarthritis
__Osteopenia
__Osteoporosis
__Pancreatitis
__Pneumonia
__Psoriasis
__Rheumatoid Arthritis
__Skin Condition
__STD
__Stomach Ulcer
__Stroke
__Thyroid Condition
__Viruses? Herpes, EBV, CMV, HPV
Other: _____

PERSONAL HEALTH HISTORY

Do you smoke? Never smoked ☐ Yes ☐ Per day?_____Years? _____ No ☐ When quit? _____

Drink alcohol? Y / N If yes, Socially ☐ Occasionally ☐ Frequently ☐ Number per week? _____

Partake in any recreational drug activity? Y / N If so, how often per day/week? _____

Do you feel refreshed after waking up? Y / N How old is your mattress and pillow? _____

Your sleep position(s)? _____ How many hours of Sleep per night on average? _____

Do you Exercise? Never ☐, Occasionally ☐, Regularly ☐, Daily ☐, Hours perweek: _____

Water consumption per day? (glasses or ounces) _____

Birth by C-Section ☐ or Normal ☐ Any birth trauma? _____ Were you Breastfed? Y / N

Bowel movements per day? ____ Do you have to strain? Y / N Constipation at times? Y / N

Hemorrhoids? Y / N Are you currently taking antacids? Y / N Are you pregnant? Y/ N

What are your stressors? _____

How do you relieve stress? _____

Are you happy with your current appearance? Y / N Are you happy with your abilities? Y / N

Tell us about any Hobbies, Special Skills, Non-work enjoyments? _____
_____

FAMILY MEDICAL HISTORY:

Write "F" for Father; "M" for Mother; "S" for Sibling, "G" for Grandparent next to each applicable condition. Feel free to elaborate.

__Alcoholism; Sober years? _____
__Alzheimer's Disease
__Anemia; Years? _____
__Asthma
__Autoimmune Diseases: _____
__Bronchitis
__Cancer (type): _____
__Cardiovascular Disease
__Celiac Disease
__Chronic Fatigue Syndrome
__Colitis
__Crohn's Disease
__Depression
__Diabetes; Type 1____ Type 2 ____
__Drug Abuse
__Eating Disorder; _____
__Eczema
__Emphysema
__Endometriosis; Surgery/Year? _____
__Epilepsy
__Fibromyalgia
__Genetic Disorder: _____
__Glaucoma
__Stomach Ulcer
__Head Injury (year(s)): _____
__Hepatitis (circle): A B C D
__High Blood Pressure
__High Cholesterol (Statin Drug? Y / N)
__HIV
__Intestinal Parasites
__Kidney Disease
__Leaky Gut Syndrome
__Mental Illness
__Migraine Headaches
__Multiple Sclerosis
__Mononucleosis
__Osteoarthritis
__Osteopenia
__Osteoporosis
__Pancreatitis
__Pneumonia
__Psoriasis
__Rheumatoid Arthritis
__Skin Condition
__STD
__Stomach Ulcer
__Stroke
__Thyroid Condition
__Other: _____

(Please Continue on the Next Page)

FOOD AND DIET HISTORY

Who prepares your meals? _____ Who do you eat your meals with? _____

Out-to-eat meals per week? _____ Do you eat after 8 pm? Y / N

Do you enjoy cooking? Y / N Are you Vegetarian or Vegan? _____

Where do you shop for your food? _____

Do you buy organic and/or conventional produce? _____

Do you buy grass-fed meats and/or conventional meats? _____

How often do you eat meat per week? _____

What kind of fats/oils do you cook with? _____

Caffeine drinks (Coffee, Red Bull, Monster, etc.)? Per week? ____

What foods do you crave? _____

Have you completed any food allergy tests? Y / N If yes, when? _____

List any known food allergies: _____

Are you on a special diet? Y / N If yes which one(s)? _____

Have you worked with a nutritionist or health coach before? If so, how long ago and for how long?

_____ Was it helpful? Y / N

YOUR PERSONAL HEALTH GOALS

What are your goals in working with us? _____

_____

What are your personal health goals (3months, 6months, 1 year)?

_____

_____

_____

We offer many services which may be not be part of your current course of care with us.

Would you be interested in information for any of the following services?

Functional Medicine____	***Stress-Reduction ___***	***Massage Therapy ___***
Neuro Feedback___	***Endo-Nasal Technique ___***	***Cranial-Sacral Therapy__***
Nutrition Counseling___	***Pantry/Food Audit___***	***Grocery Store tours___***
	Meal Preparation___	