WELLNESS with Dr. Dan

Confidential Client Information

Name _____ Birthdate _____

Address _____ City, State, Zip_____

Cell # _____ Email _____

Marital Status _____ Spouse's Name _____

Occupation _____ Employer _____

Who referred you to Dr. Dan? _____

Chief complaint:

Primary Care Physician(s) (When was your last check-up/complete Physical Exam?)

RELEVANT PAST MEDICAL HISTORY:

Injuries/Surgeries _____

_____

_____

Allergies (Food, Airborne) _____

Medications/Supplements that you are currently taking on a daily basis: _____

HEALTH HABITS:

1. **What do you eat?** (ex. Fruits/Veggies, Cooked Foods, Junk Food, Processed Food, Restaurant Food)

   For Breakfast _____

   For Lunch _____

   For Dinner _____

2. **How much Water do you drink per day (in ounces)?** _____
3. **What do you drink besides Water?** _____
4. **How do you Exercise?** _____
5. **How well do you Sleep?** _____
6. **What do you do to Relax?** _____

_____

Dr. Dan, I have read all of the above information and answered all questions accurately & honestly.

Signature of Client _____ Date ____/____/____

Signature of Guardian (if a minor) _____

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PHYSICAL ANALYSIS (To be completed by Dr. Dan)

Standing Forward Head Carriage (FHC) _____

Standing Ear Level Discrepancy (ELD) _____

Standing Hip Strength Discrepancy (HSD) _____

Prone Leg Length Discrepancy (LLD) _____

Prone Sacral Base Movement (SBM) _____