Welcome to True Life Wellness!

Important: Please Read!

We are excited that you are with us today. Below is a brief outline of what you can expect during your visit. We are here to serve you, so if you have any questions or concerns, please ask any of us at True Life Wellness.

Paperwork

Please complete this simple admitting paperwork as thoroughly as possible so we can have an understanding of your current state of health and your health goals.

Consultation

You will meet Dr. Molstre and discuss your health concerns and health goals. After reviewing the information on your history form and asking some additional questions, Dr. Molstre will determine whether or not he may be able to assist you in your health concerns.

Examination

The following information may be gathered during the examination, depending on what Dr. Molstre feels is necessary for your case:

- ✓ Comprehensive Chiropractic Evaluation
- ✓ Computerized Thermal Scan
- ✓ Computerized Surface Electromyography Scan
- ✓ Computerized Heart Rate Variability
- ✓ Functional Assessments and Bilateral Foot Scans
- ✓ Motion Study Analysis

X-Rays

This office routinely x-rays all qualifying new patients. These x-rays act like a "road map" for Dr. Molstre. Without a road map, it is difficult to get the greatest possible results in the shortest possible period of time!

Report of Findings

Upon gathering the information from the examination and x-rays, we will schedule you a time for the Doctor's Report with Dr. Molstre. This is the most important appointment, as Dr. Molstre will take time to review your results and prepare an action plan tailored to YOUR goals and needs. This appointment will thoroughly explain the findings from the first visit as well as care recommendations.

NEW PATIENT INTAKE

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: cell: (_____)_____-_____ work: (_____)_____-_____ home: (_____)_____-_____

Email address: _____ Male _____ Female _____

Social Security #: _____-_____-_____ Birth Date: _____/_____/_____ Age: _____

Occupation: _____

Employer Name & Address: _____

Single _____ Married ___ _____ Spouse's Name: ___ _____

Have you seen a Chiropractor before? YES NO If yes, when? _____

Whom may we thank for referring you to our office? _____

YOUR HEALTH SUMMARY

Please ✓ check all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins & Needles in legs	☐ Fainting	☐ Neck pain
☐ Pins & needles in arms	☐ Loss of smell	☐ Back pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Sensitive stomach
☐ Fatigue	☐ Depression	☐ Irritability	☐ Muscle tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold sweats	☐ Light bothers eyes	☐ Problem urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual pain	☐ Menstrual irregularity	☐ Ulcers

List any medications you are taking: _____

_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____