BATSON CHIROPRACTIC GROUP

2517 Lebanon Pike, Suite 101
Nashville, Tennessee 37214
615.751.0958

BATSON CHIROHEALTH GROUP

Kelli Thomas, ND Wellness Practitioner

Name: _____ Date: _____ DOB: _____

Age: _____ Female or Male

Home Address:

_____

_____

Marital Status: Single, Married (spouse's name_____), Widowed, Divorced

Do you have children: _____. If yes, how many_____?

Ages: _____

Email Address: _____

Best number to be reached (specify home, mobile, work): _____

Hobbies: _____

Occupation: _____

Employer (Name and Address) : _____

_____

Medical Doctor: _____

Phone Number: _____

Emergency Contact & Phone Number:

_____

Please list the main complaint & specify examples of how it affects your everyday life.

_____

_____

(OVER PLEASE)

BY COMPLETING THIS PACKET PRIOR TO YOUR APPOINTMENT, YOU'RE HELPING US HONOR YOUR SCHEDULED TIME. THANK YOU!

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Please list any past or present allergies (to include food & medications):

_____

_____

List of current medications:

_____

_____

List of current vitamins or supplements:

_____

_____

Have you seen or do you currently see an acupuncturist, chiropractor, massage therapist, physical therapist, counselor, herbalist, naturopath, etc.? If so, please describe the type of practitioner, name, dates, and if benefit/relief was/is received.

_____

_____

_____

What do you consider the status of your current health? _____

On a scale of 0 to 10 (0 being the worst and 10 being the best), what would you rank your current health status? _____

Have you ever done any type of cleanse or purification program before? _____

If so, what type, was it a positive experience and you receive benefit?

_____

_____

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Have you ever smoked? _____

Do you smoke? _____ If so, how much? _____

Do you drink? _____ If so, how much? _____

Mother living? YES/NO… Father living? YES/NO… Please list current age & if in good health, or age at death & any pertinent family medical history:

_____

_____

** Check all that apply regarding your personal and family history in the below chart. If the condition applies to a family member, please write which family member in which it applies to.

Condition	You	Family	Condition	You	Family	Condition	You	Family
Acid Reflux/GERD			Headaches/Migraines			Osteoarthritis		
Alcoholism			Heart Attack			Osteoporosis		
Aneurysm			Hepatitis			Rheumatoid Arthritis		
Anxiety			High Blood Pressure			Seasonal Allergies		
Asthma			High Cholesterol			Seizures		
Blood Clots			Kidney Disease			Sleep Apnea		
Cancer			Kidney Stones			STD/HIV		
Depression			Liver Problems			Stroke		
Emphysema/COPD			Lupus			Substance Abuse		
Gout			Obesity			Thyroid Problems		

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** Complete the chart below as it relates to screening/prevention:

Screening/ Prevention Test	Year	Screening/ Prevention Test	Year	Screening/ Prevention Test	Year
Cholesterol Check		Physical Exam		For Women: Bone Density Test	
Colonoscopy		Pneumonia Vaccine		For Women: Mammogram	
Diabetes Check		Tetanus Shot		For Women: Pap Smear	
Flu Vaccine		For Men: Prostate Exam			

** Please complete the following information if you have or have had any symptoms in the past year:

Body System	Symptoms
Dermatology/Skin (Example: Eczema, Rash, Irregular Moles, Discolored Skin)	
Head, Ears, Nose, Throat (Example: Ear ringing, Sinus Issues, Mouth Sores)	
Cardiovascular (Example: Chest Pain, Heart Problems, Fainting)	
Respiratory (Example: Wheezing, Shortness of Breath, Snoring)	
Gastrointestinal (Example: Stomach Pain, Nausea, Vomiting, Constipation	
Genitourinary (Example: Kidney/Bladder Infections, Pain with Urination)	
Lymphatic/Hematologic (Example: Easy Bruising, Easy Bleeding, Swollen Glands)	
Musculoskeletal (Example: Swollen Joints, Muscle Spasms, Muscle Cramps)	
Endocrine (Example: Thyroid Problems, Diabetes)	
Psychiatric/Neurological (Example: Headaches, Dizziness, Tremors, Poor Balance)	
Female/Male Specific (Example: Irregular Periods, Pregnancy/Prostate Problems)	
Other	

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Please list any past or present health conditions:

_____

_____

Please list all surgeries and corresponding conditions:

_____

_____

History of any vaccines, immunizations, shots in the past, if so, which ones?

_____

_____

Please list foods you ate yesterday:

_____

_____

Please list any foods you eat on a regular basis or foods you tend to avoid:

_____

_____

Please list anything else in your medical history that you feel is relevant:

_____

_____

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