Chiropractic & Wellness SPECIALISTS

NEW PATIENT APPLICATION

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: _____

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 ☐ Craniosacral work

Office Use: BP ____/____ O2 Sat ____ HR _____ Height _____ Weight _____Taken by _____

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

Have you had Chiropractic care in the past? Y / N If yes, the most recent? _____

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

1._____ 2._____

3._____ 4._____

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

Have you taken **antibiotics** within the last 5 years? Y / N Antibiotics when you were a child? Y / N

Have you ever suffered ***TRAUMATIC*** injury? (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

<u>Medical History</u> Put a *"check mark"* for <u>Self</u> and/or "F" for <u>Father</u>; "M" for <u>Mother</u>; "S" for <u>Sibling</u>, "G" for <u>Grandparent</u> 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
__Viruses? Herpes, EBV, CMV, HPV
__Other: _____

<u>PERSONAL HEALTH HISTORY</u>

☐ smoke tobacco? Never smoked No When did you quit? _____ Yes Per day?_____ Years? _____

☐ 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 or 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? _____

☐ you Exercise? Never Occasionally Regularly Daily Hours per week: _____

What is the most you've ever weighed? _____

☐ birth by: C-Section or Natural 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 Weeks? _____

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? _____

_____

FOOD AND DIET HISTORY

Sometimes eat after 8 pm? Y / N How often per week do you eat fast food? _____

What food(s) do you crave? _____ Are you Vegetarian or Vegan? _____

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

List any known food allergies: _____

Water consumption per day? (glasses or ounces) _____

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

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_____

6 months _____

1 year _____

We offer many services which may 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____	***Nutrition Counseling_____***	***Chronic Sinus Issue's____***
Massage Therapy _____	***Nutritional Ed. Classes____***	***Cranial-Sacral Therapy____***
Stress-Reduction _____	***Essential Oil Consult ____***	***Bio/Neuro Feedback____***