941WELLNESS
Confidential Patient Data

Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PATIENT INFORMATION

Today's Date:_____

(Please Print)

Legal Name:_____ Date of Birth:_____

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

Social Security #:___-___-_____ Age:_____ ❑ Male ❑ Female

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Do you prefer to receive calls at: ❑Home ❑Cell ❑Work May we leave a message? ❑Yes ❑No

May we leave an appointment reminder or message with a person who may also answer this number if you are unavailable? ❑Yes ❑No *(Please note we will ask this person either to have you call us back where we will leave our office information with them, ask them to remind you of a scheduled appointment, ask them to let you know your products have arrived at the office, or ask if you are on your way to an appointment if you are running late.)*

E-mail (used only for appointment reminders or office news): _____

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Minor ❑Widowed ❑Partnered

If Minor, Legal Guardianôs Name: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____

Emergency Contactôs Phone Number: (___)_____

Your Occupation: _____ Your Employer: _____

Referred to this Office by: ❑Friend/Family Member - Name?_____

❑Advertisement ❑ Internet ❑Clinic Location ❑Other_____

RESPONSIBLE PARTY:

(Please Print)

Name of person responsible for this account: _____

Relationship to Patient: _____ Phone Number: (___)_____

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

Payment is required for all services at the time they are rendered. We accept cash, personal checks, Visa, and MasterCard.

Your signature below signifies your understanding and willingness to comply with our payment policy. It also certifies that the information you have provided is correct.

Signature of Patient or Legal Guardian: _____ Date: _____

PRESENT MAJOR COMPLAINTS:

Please place a circle on any area of pain or complaint and use the following symbols to describe what you are feeling:

A ï Aching

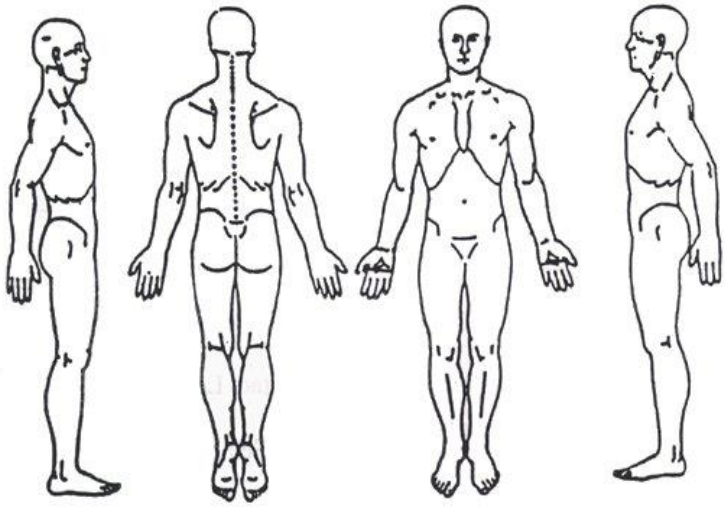
S ï Sharp / Stabbing

B ï Burning

N ï Numbness

T ï Tingling / Pins and Needles

O - Other



Please Describe and Rate your symptoms and List Your Primary Reason(s) for Visit 1-10 (1 being least serious)

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

6._____ _____

SYMPTOMS ARE WORSE IN THE: ❑MORNING ❑AFTERNOON ❑NIGHT

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET **DATE OCCURRED:** _____

HOW OCCURRED? _____

_____

SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)

SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑BENDING ❑REACHING ❑COUGHING ❑SITTING ❑TURNING HEAD

❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

_____

_____

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss/ confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

_____

_____

MEDICAL HISTORY:

(Please check the medical conditions you have had or are currently experiencing).

❑ AIDS	❑ Heart Disorder	❑ Pacemaker
❑ Anemia	❑ Hepatitis	❑ Parkinson's Disease
❑ Arthritis	❑ Hernia	❑ Pinched Nerve
❑ Asthma	❑ Herniated Disc	❑ Polio
❑ Back Pain	❑ High Blood Pressure	❑ Poor circulation
❑ Bladder Trouble	❑ High Cholesterol	❑ Prosthesis
❑ Bone Fracture	❑ HIV/ARC	❑ Psychological disorders
❑ Bowel Control Loss	❑ Indigestion	❑ Reproductive disorders
❑ Cancer	❑ Kidney Disorder	❑ Rheumatic fever
❑ Chest Pain	❑ Liver Disorder	❑ Rheumatism
❑ Chicken Pox	❑ Menstrual Cramps	❑ Rheumatoid Arthritis
❑ Concussion	❑ Migraine Headaches	❑ Scarlet fever
❑ Convulsions	❑ Miscarriage	❑ Serious injury
❑ Diabetes	❑ Mononucleosis	❑ Sinus trouble
❑ Dislocated Joints	❑ Multiple Sclerosis	❑ Stroke
❑ Eating Disorder	❑ Muscular Dystrophy	❑ Thyroid Problems
❑ Epilepsy	❑ Neck pain	❑ Tuberculosis
❑ German Measles	❑ Nervousness	❑ Ulcers
❑ Gout	❑ Numbness	❑ Vaginal Infections
❑ Headaches	❑ Osteoporosis	❑ Venereal Disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_____

_____

Date of Last Physical Exam: _____/_____/_____

WOMEN ONLY:

ARE YOU PREGNANT? ❑NO ❑YES

DATE OF LAST MENSTRUAL PERIOD: _____

CURRENT MEDICATIONS:	DOSE:	TIMES/DAY:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT HERBS, VITAMINS & SUPPLEMENTS:	DOSE:	TIMES/DAY:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑NO ❑YES (If Yes, Please List Below)

Medication: _____ **Reaction:** _____

_____ _____

_____ _____

_____ _____

OTHER ALLERGIES: _____

_____

_____

DAILY HABITS:

Do you exercise on a regular basis? ❑NO ❑YES **If yes, how often?** _____

What type of exercise activities do you do? _____

How do you feel after exercise? _____

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

_____

Have you experienced any major stress in the last six months? _____

_____

Do you smoke? ❑NO ❑YES **How much per day?** _____

How much liquor do you consume on a weekly basis? _____

How much coffee, tea, or caffeinated beverages do you consume on a daily basis? _____

SURGICAL HISTORY:

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

Have you ever had a metal implant? ❑Yes ❑No

ACCIDENT HISTORY:

❑Job ❑Auto ❑Other 1. _____ Date:_____

❑Job ❑Auto ❑Other 2._____ Date:_____

❑Job ❑Auto ❑Other 3._____ Date:_____

Non-Chiropractic Patients: Please Answer These Additional Questions:

Describe your sleep regularity: _____

Describe your typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What Are Your Favorite Types of Foods? ❑Spicy ❑Bland ❑Sweet ❑Sour ❑Solids ❑Liquids ❑Hot ❑Cold

Do You Prefer ❑Cooler or ❑Warmer Temperatures?

What Is Your Favorite Season? ❑Spring ❑Summer ❑Fall ❑Winter

Rate Your General Energy Level On A Scale Of 1-10 (1=very low, 10=very high): _____

Certification:

To the best of my knowledge, the preceding information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health, medication, or contact information.

Your signature below signifies your understanding and certifies that the information you have provided is correct.

Signature of Patient or Legal Guardian: _____ Date: _____

_____ _____

Please print name of Patient, Guardian or Personal Representative | Relationship to Patient