Wellness Centers
Caring for you. Caring about you.
CHIROPRACTIC | MASSAGE THERAPY | WEIGHT LOSS

Date:_____

Name_____Age_____Date of Birth____/____/____
(First) (Middle) (Last)

Address_____
(Number) (Street) (City) (State & Zip)

Phone_____Cell_____Email_____

Social Security Number_____ Primary Doctor_____

Employer_____Work Phone_____Marital Status_____

Spouse's Name/Phone #_____

Insured Name (if different from above):_____SSN_____DOB_____

Guarantor (if different from above):_____SSN_____DOB_____

Address_____Phone_____Alternate Phone_____

Have you had previous chiropractic care?_____ Who referred you to this office? _____
Please list:
Any surgeries_____
Major accidents/falls_____
Family history (illness such as tuberculosis, diabetes, cancer, high blood pressure, etc. for yourself and immediate family)_____
_____

FEMALE HISTORY: Date of last menstrual cycle_____ Regular _____Irregular_____
Do you take birth control pills? _____ Are you pregnant? _____

Have you previously sought medical treatment for you complaints? _____
If yes, please explain_____
Doctors previously seen _____
Are your complaints related to an accident? _____ Yes _____ NO Date of accident ___/___/___

If this is an accident or work related injury please ask the receptionist for additional forms.

Race (circle only one)

American Indian
Asian
Black or African American
Other Pacific Islander
Alaska Native
White
Native to Hawaiian
Declined to State

Ethnicity (circle only one)

Hispanic or Latino
Declined to State
Not Hispanic or Latino

Smoking Status (circle only one)

Current Every Day Smoker
Current Some Day Smoker
Former Smoker
Never Smoker

Smoking Start Date:_____End Date_____

In effort to quit smoking, I am currently taking: _____

Do you have any allergies to medication? Yes No

If yes, please indicate the following:

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

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Reaction: _____
Start Date: _____
End Date: _____

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Reaction: _____
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End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Are you currently taking any medication? Yes No

If yes, please indicate the following:

Medication: _____
Route: Oral / Intravenous / Other:_____
Frequency: _____
Began Use: _____
Discontinued use: _____

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Major Complaints: (Be Specific)

A) _____ **D)** _____

_____ _____

B) _____ **E)** _____

_____ _____

C) _____ **F)** _____

_____ _____

Medications: _____

1. **Which of your major complaints bother you the most (Check one or more) [ ]A [ ]B[ ]C [ ]D [ ]E [ ]F**
2. **How long have you had this complaint(s)?** _____

   _____

   _____
3. **Prior to the problem beginning, did you ever have an earlier problem that was the same or similar?**

   _____

   _____

   _____
4. **Did it appear [ ] Slowly? [ ] Immediately?**
5. **Does anyone else in your family have this problem or a similar one?** _____

   _____
6. **How often does it bother you now?** _____
7. **When it is at its worst, how does it feel?** _____
8. **When it is at its worst, how does it interfere with your normal daily activities?** _____

   _____
9. **Does this problem reduce your productivity or effectiveness regarding your work?** _____

   _____
10. **Does it create any problems with your relationships? [ ]YES [ ]NO**

    If yes, how?_____
11. **What have you done to aggravate the problem and/or what have you failed to do that would have helped get rid of it?**

    _____
12. **If your problem was left unhandled for five years, how do you think it would affect you?** _____

    _____
13. **Are you committed to getting rid of not only your symptom(s) but what caused it, even if it requires a change in your life-style? [ ]YES [ ]NO**
14. **(If Children) Tell me about your children:** _____

    _____

Auto Accident:_____

_____

Personal Injury (PI) [ ]YES [ ]NO Head Position [ ]Straight Ahead [ ]Rotated (Which Way?)_____

MPH on Impact_____ **Amount of Damage to Vehicle** _____ **Ft. of Acceleration**_____

Kind of Car_____ _____**Their Car**_____ _____**Position of Head Rest**_____