Holistic Chiropractic & Wellness
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PATIENT INFORMATION

Name:_____ Date:_____

What You Prefer To Be Called: _____ Sex: [ ] M [ ] F Marital Status: [ ] M [ ] S [ ] D [ ] W

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

Home Phone:_____ Mobile:_____ Social Security #:_____

Age:_____ Birthdate:_____ Emergency Contact:_____

Address:_____ City:_____ State:_____ Phone:_____

Email:_____ May we email you our wellness newsletter? [ ] Y [ ] N

Who may we thank for your first visit? Referred By:_____ OR [ ] Website [ ] Google [ ] Other

Occupation:_____ Employer:_____

Work Address:_____ Work Number:_____

Significant Other's Name:_____ Do you have children? [ ] Y [ ] N Ages:_____

EMPLOYER:

MEDICAL HISTORY AND SYMPTOM / PAIN INFORMATION

(Additional room provided to answer questions on the back of this form)

A. Reason for today's visit: [ ] work [ ] auto [ ] sports/competition [ ] trauma [ ] stress [ ] anxiety [ ] chronic [ ] other

B. Explain what happened:_____ ->

C. Please describe the pain intensity and its location on the included "Pain Diagram" page.

D. When did this condition begin? ___/___/___ Is it getting worse? [ ] Y [ ] N [ ] Constant [ ] Comes & Goes

E. Is this condition interfering with your: [ ] work [ ] sleep [ ] daily routine [ ] relationships Please explain _____ ->

F. Have you had this or similar conditions in the past? [ ] Y [ ] N Please explain_____ ->

G. Have you ever been treated by a Medical Physician for this condition? [ ] Y [ ] N If so, where_____ ->

H. Have you ever been treated by a Chiropractic Physician? [ ] Y [ ] N If so, for what_____ ->

I. Please list any falls, slips, concussions, or accidents you may have had with dates:_____ ->

J. Family Health History (genetics, your environment, epigenetics):_____ ->

K. The feet are the foundation of your body. Are you now wearing? [ ] heel lifts [ ] sole lifts [ ] inner soles

[ ] arch supports [ ] custom-made orthotics

SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS

[ ] High Blood Pressure
[ ] Cholesterol
[ ] Thyroid Imbalance
[ ] Insulin Resistance/Diabetes
[ ] Headaches: Migraine, Tension
[ ] Fibromyalgia
[ ] [ ] Weight gain/loss
[ ] Stress, Anxiety, Depression
[ ] Nightmares
[ ] Trauma: Physical/Emotional
[ ] Loss of Family Member/Friend
[ ] Insomnia
[ ] Mood Swings
[ ] Joint Pain
[ ] Posture
[ ] Fallen-arches
[ ] ADDICTIONS

A.

B.

C.

D.

E.

F.

G.

H.

I.

J.

K.

Name:_____ Health History Intake Form Date:_____

Email: _____ Phone: _____

What are your health goals?

☐ Remove Pain
☐ Gain More Energy/Stamina
☐ Restore Health/Reduce Illness
☐ Achieve Optimal Wellness

What are your top 3 health complaints?

1)_____
2)_____
3)_____

Question	Y N	Patient Comment	Practitioner Comment
Are you on a particular diet or currently restricting certain foods?	Y N		
Do certain foods upset your stomach or cause constipation, IBS, or headaches?	Y N		
Do you have certain food cravings?	Y N		
Do you get shaky or anxious between meals?	Y N		
Do you drink **less** than half your body weight in water oz daily? (ex: if you weigh 150 lbs, 75 oz would be your daily water intake)	Y N		
Do you drink soda, sports, or energy drinks?	Y N		
Do you chew gum, drink diet drinks or consume sugar-free foods?	Y N		
Have you ever been unconscious, had a concussion, whiplash, closed head injury?	Y N		
Do you get muscle cramps, "charley horses", or eye twitches?	Y N		
Do you frequently use Tylenol, Ibuprofen, or other pain relief medications? (How many milligrams? How often?)	Y N		
Have you taken fish oil & had difficulty keeping it down?	Y N		
Do you have indigestion, belching, gas or bloating?	Y N		
Do you typically go **more** than 24 hours **without** a bowel movement?	Y N		
Have you had any organs surgically removed or medically altered? (appendix, gallbladder, etc.)	Y N		
Have you gained more than 15 lbs in the past year?	Y N		
Do you grind your teeth while you sleep?	Y N		
Do you have trouble falling or staying asleep?	Y N		
Have you had an illness that you have not fully recovered from?	Y N		

Do you have a health diagnosis or are you concerned with any of the following:

☐ High Blood Pressure
☐ Cholesterol
☐ Insulin Resistance (Diabetes)
☐ Thyroid Imbalance
☐ Arthritis
☐ Fibromialgia
☐ Cardiovascular
☐ Migraines/Headaches
☐ Stress
☐ Other_____

Please list all medications, supplements, and herbs that you a currently taking:_____

_____
_____
_____
_____
_____

Is there anything else you think I should be aware of: _____

_____
_____
_____
_____

AUTO / WORK RELATED ACCIDENT

one

ABOUT YOU

Today's Date: ___/___/___ File #: _____

Name: _____

two

AUTO RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.

Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger

If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle? _____

Did the police come to the accident site? . . ❑ Yes ❑

Was a police report filed? . . . . . ❑ Yes ❑

Were there any witnesses? . . . . . ❑ Yes ❑

Were you wearing your seat belt? . . . . . ❑ Yes ❑

Was this vehicle equipped with airbags? . . ❑ Yes ❑

If yes, did it/they inflate? . . . . . ❑ Yes ❑

In relation to the base of your skull, where was the headrest? . . . . . ❑ Above ❑ Below ❑ At base of s

What did your vehicle impact? ❑ Another vehicle ❑ Ot

If other, explain: _____

Did any part of your body strike anything in the vehicle? ❑ Yes ❑

If yes, please describe: _____

_____

Make & model of the vehicle you were occupying?

_____

Name of the location/street on which you were traveli

_____

In which direction were you headed? ❑N ❑S ❑E

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the:

❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Otl

During impact, were you facing: ❑ Right ❑ Left ❑ Forv

Were you ❑ aware or ❑ surprised by the impact?

If accident vehicle made impact with another vehicle.

Make and model of that other vehicle? _____

_____

Direction other vehicle was headed? ❑N ❑S ❑E

Speed of the other vehicle? _____

In your words, please describe the accident: _____

_____

_____

_____

two b

WORK RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.

Was your accident directly related to your work?

❑ Yes ❑ No

Briefly describe the events that occurred just before and during your accident: _____

_____

_____

Give the address where accident occurred: (if other than employer's address) _____

_____

Was anyone else present during your accident?

❑ Yes ❑ No

Did you report your accident to your employer?

❑ Yes ❑ No

What recommendations did your employer make just after your accident? _____

_____

Has this type of accident happened to you before?

❑ Yes ❑ No

To the best of your knowledge, has this accident occurred in your workplace before? . . . . . ❑ Yes ❑ No

In general:

Is your job physically stressful? . . . . . ❑ Yes ❑ No

Is your job mentally stressful? . . . . . ❑ Yes ❑ No

Is your workplace noisy? . . . . . ❑ Yes ❑ No

Have you changed jobs in the last year? ❑ Yes ❑ No

PLEASE CONTINUE ON B

three AFTER INJURY

Did accident render you unconscious? ..... ❑ Yes ❑ No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any other Doctor? ❑ Yes ❑ No

When did you go? ❑ Just after accident ❑ The next day ❑ 2 days plus

How did you get there? ❑ Ambulance or ❑ Private transportation

Name of Hospital and/or Attending doctor: _____

_____

Was he/she a: ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Describe any treatment you received: _____

_____

Were X-rays taken? ..... ❑ Yes ❑ No

Was medication prescribed? ..... ❑ Yes ❑ No

Have you been able to work since this injury? ❑ Yes ❑ No

Are your work activities restricted as a result of this injury? ❑ Yes ❑ No

Indicate ☑ the symptoms that are a result of this accident:

❑ Dizziness	❑ Difficulty sleeping	❑ Jaw problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/Shoulder pain	❑ Back pain
❑ Headache(s)	❑ Fatigue	❑ Numb Hands/Fingers	❑ Lower back pain
❑ Blurred vision	❑ Tension	❑ Chest pain	❑ Back stiffness
❑ Buzzing in ear	❑ Neck pain	❑ Shortness of breath	❑ Leg pain
❑ Ears ringing	❑ Neck stiff	❑ Stomach upset	❑ Numb Feet/Toes

❑ Other _____

Is your condition getting worse?

❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable even if only sometimes	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Lovemaking	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

Have you retained an attorney: ❑ Yes ❑ No

If yes, whom: _____

His/Her Phone #: _____

four RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____

Please indicate ☑ your daily job duties and any activities which you are occasionally asked to perform.

❑ Standing	❑ Driving	❑ Operating equipment
❑ Sitting	❑ Twisting	❑ Work with arms above heac
❑ Walking	❑ Crawling	❑ Typing
❑ Lifting	❑ Bending	❑ Stooping

❑ Other _____

What positions can you work in with minimum physical effort and for how long? _____ ❑ N/

Prior to the injury were you capable of working on an equal basis with others your age? .. ❑ Yes ❑ No ❑ N/

Do you work with others who can help you with any heavy lifting? ..... ❑ Yes ❑ No ❑ N/

While in recovery, is there any light duty work you could request? ..... ❑ Yes ❑ No ❑ N/

five ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured's SS #: _____ D.O.B. ___/___/___

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has chang please inform our front desk personnel.

Please remember you are ultimately responsible for you account.

_____ SIGNATURE ___/___/___ DATE

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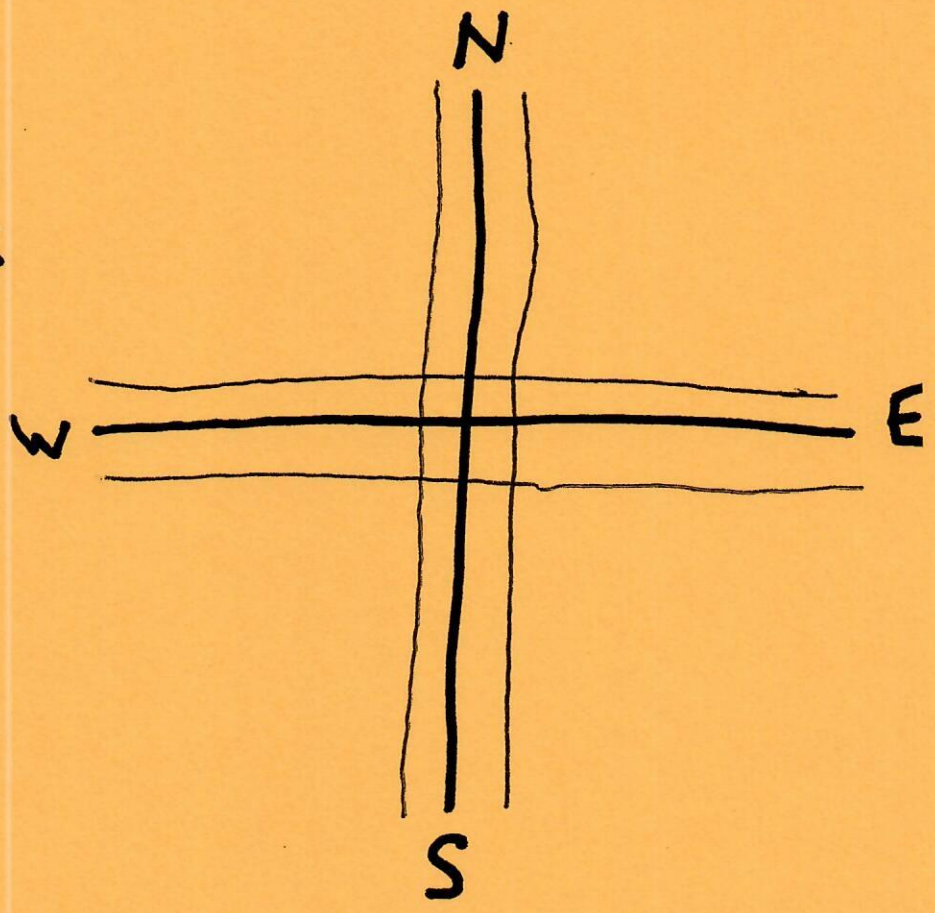
PLEASE DRAW A SIMPLE DIAGRAM OF YOUR ACCIDENT:

MY CAR = MC

OTHER CAR = OC

3RD CAR = 3C



OTHER NOTES:

DID POLICE COME TO THE ACCIDENT?

WAS A CITATION GIVEN? TO WHOM?

General Pain Disability Index Questionnaire

Name (please print): _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

Use the letters below to indicate the type and location of your sensations right now

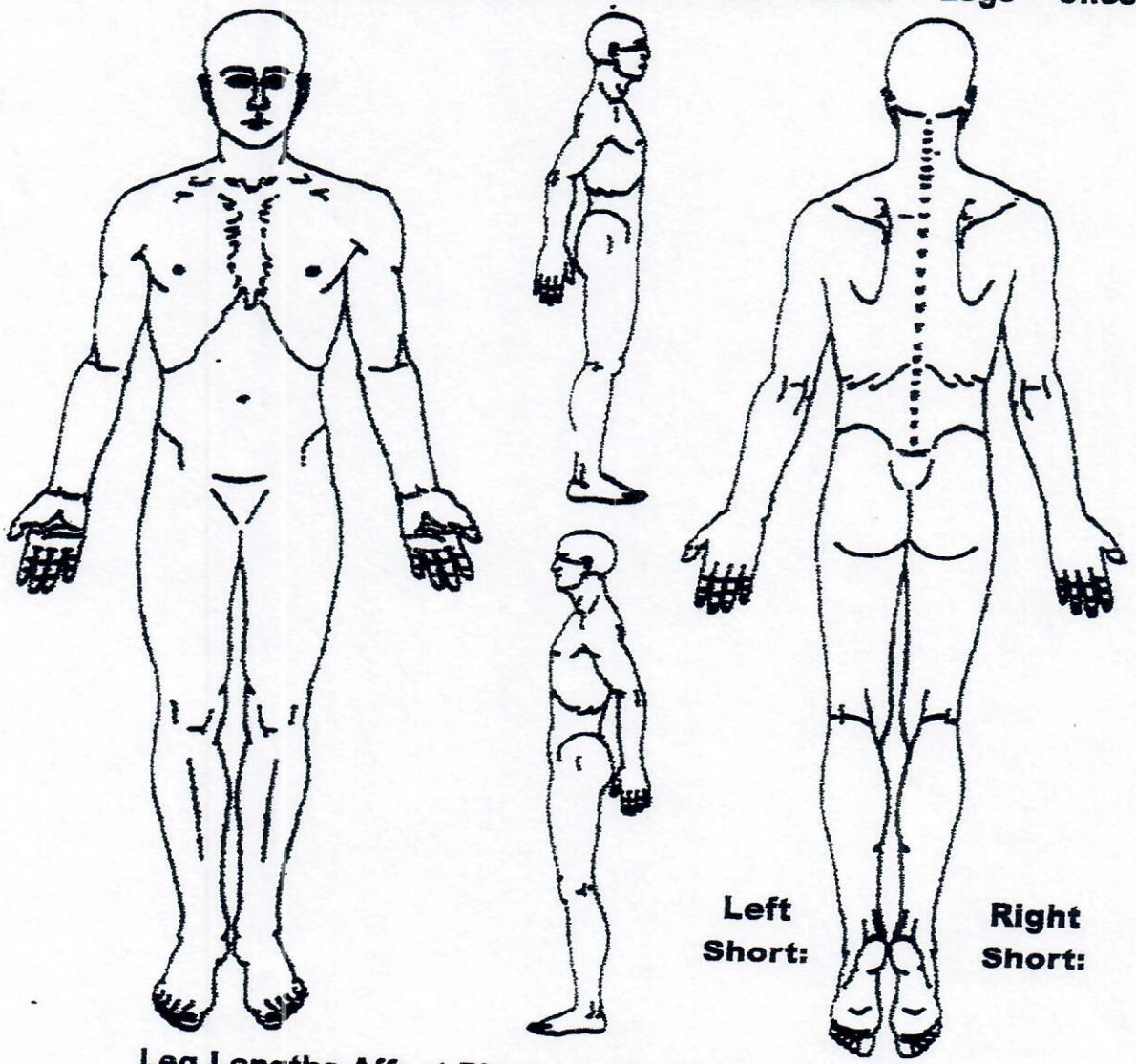
Key:

A = Ache
P = Pins & Needles.
B = Burning
S = Stabbing
N = Numbness
O = Others

Circle → R → Radiating into: Head Face Arms Legs Chest

Height:

Weight:



Left Short:

Right Short:

Leg Lengths Affect Physical - Emotional Stability

What activities do you do for exercise? _____

What activities are you unable to do? _____

DATE NAME: #

IMPORTANT: Please check (X) all present REVIEW OF SYMPTOMS

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R - L)
- ☐ Pain across shoulders
- ☐ Bursitis (R - L)
- ☐ Arthritis (R - L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R - L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Numbness in arms (R - L)
- ☐ Numbness in fingers (R - L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull Ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:
- Low back pain
  - Upper lumbar
  - Lower lumbar
  - Sacroilliac
- Low back pain is worse when:
  - working
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
  - lying down (sleeping)
  - walking
- Pain relieves when
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

HIPS, LEGS & FEET:
- Pain in buttocks (R - L)
- Pain in hip joint (R - L)
- Pain down leg (R - L)
- Pain down both legs
- Knee pain
  - Inside
  - Outside
- Leg cramps
- Cramps in feet (R - L)
- Pins & needles in legs (R - L)
- Numbness of leg (R - L)
- Numbness of feet (R - L)
- Numbness of toes
- Feet feel cold
- Swollen ankles (R - L)
- Swollen feet (R - L)

WOMEN ONLY:
- ☐ Menstrual pain _____ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____ days
- ☐ Birth control _____ (type)
- ☐ Hysterectomy
- ☐ Genital cancer _____
- ☐ Discharge
- ☐ Menopause _____
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you are pregnant?

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep
- ☐ Loss of sleep _____ hrs /night
- ☐ Loss of weight _____ lbs.
- ☐ Gain weight _____ lbs
- ☐ Coffee _____ cups/day
- Tea _____ cups/day
- Cigarettes _____ pack/day
- Other _____
- Diabetes
- Hypoglycemia

REMARKS:

REV 11/94