



A Natural Health and Wellness Center

### Patient Information

Please help us provide you with a complete & thorough evaluation by completing this form thoroughly.

#### General Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
(Number, Street) (City) (State) (Zip Code)

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Email Address: \_\_\_\_\_  Check if you do not wish to receive email correspondence

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Birth Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Status:  Single  Married  Partner  Separated  Divorced  Widowed

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Number of Children \_\_\_\_\_ and their ages: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Have you previously seen a chiropractor?  Yes  No

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Other Physicians:

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

If necessary, do you give permission to share information and/or consult with your other healthcare providers?  Yes  No

How did you find out about us?

Current Patient \_\_\_\_\_  Internet  Event \_\_\_\_\_

Health Talk \_\_\_\_\_  Other \_\_\_\_\_

Would you like to receive free health information from this office?  Yes  No

#### Health Information

Primary Concern/Problem: \_\_\_\_\_

How long have you had this problem(s)? \_\_\_\_\_

Please list any other illnesses or conditions for which you are currently receiving medical treatments or therapy: \_\_\_\_\_

**Health Information – continued**

Other Concerns (list in order of priority): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list previous medical procedures, surgeries, hospitalizations and injuries (include auto accidents, falls, etc.):

Accident/Surgery/hospitalization	Details	Year

Please list all medications and/or supplements you are currently taking:

Medications	Supplements

Please list any allergies you have:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family Medical History**

Please list any significant diseases prevalent in your family:  
 \_\_\_\_\_  
 \_\_\_\_\_

Please check any conditions you currently or previously have had:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Low back pain             | <input type="checkbox"/> AIDS/HIV                | <input type="checkbox"/> Polio               |
| <input type="checkbox"/> Pain between shoulders    | <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Arteriosclerosis    |
| <input type="checkbox"/> Neck pain                 | <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Poor Appetite       |
| <input type="checkbox"/> Arm pain                  | <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Heart attack/Angina |
| <input type="checkbox"/> Joint pain/Stiffness      | <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Poor balance              | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> Numbness                  | <input type="checkbox"/> Anorexia/Bulimia        | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Paralysis                 | <input type="checkbox"/> Chicken pox             | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> Cold/tingling extremities | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Thyroid disease     |
| <input type="checkbox"/> Stress                    | <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Bladder infections  |
| <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> Appendicitis            | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Trouble sleeping          | <input type="checkbox"/> Cold sores              | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Other: _____        |
- Which organs have you had removed?  Gall bladder  Tonsils  Appendix  Other \_\_\_\_\_

## Health Information – continued

Are you currently pregnant? Yes No Due Date: \_\_\_\_\_

### Habits

- Smoking \_\_\_\_\_ Packs/Day
- Alcohol \_\_\_\_\_ Drinks/Week
- Coffee/Caffeine \_\_\_\_\_ Cups/Week
- High Stress Level Key contributors: \_\_\_\_\_

### Exercise

- None
- Moderate
- Daily
- Heavy

### Health Goals

What are your top 3 health goals?

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Is there anything else we should know? \_\_\_\_\_  
\_\_\_\_\_

## Insurance Information

Insurance Company: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Important:** In order to bill an insurance company, we need to know the name of the primary policy holder. If you are not primary, it may be your spouse or parent.

Are you the Primary Insured? Yes No

If not:

Name of Primary Insured person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth for Primary Insured: \_\_\_\_\_

Assignment and Release:

I understand that I am financially responsible for all charges whether or not paid by insurance or any third party.

Patient Signature \_\_\_\_\_ Today's Date \_\_\_\_\_