Creating Wellness

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I. Personal Information

NAME_____ LIKE TO BE CALLED "_____" PATIENT#_____ DATE_____

DATE OF BIRTH_____ SEX AT BIRTH ☐MALE ☐FEMALE IDENTIFY AS ☐MALE ☐FEMALE ☐NON-BINARY

PREFERRED PRONOUNS ☐SHE / HER ☐HE / HIM ☐THEY / THEM

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE #_____ WORK #_____ CELL #_____

☐ SINGLE ☐ MARRIED/PARTNER ☐ DIVORCED ☐ WIDOWED

OF CHILDREN / DEPENDENTS_____ NAME(S) /AGE / GENDER_____

OCCUPATION_____ EMPLOYER NAME _____

HOW DID YOU FIND US? ☐ REFFERAL (WHO REFERRED YOU)_____ ☐OTHER_____

II. Your Health Profile

1. Why This Form Is Important

As a Creating Wellness Center, we focus on your ability to be healthy. Our goals are to:

- First, address the issues that brought you to this center.
- Second, offer you the opportunity of improved health, wellness and quality of life in the future.

Daily, we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Often, the effects are gradual and are not felt until they become serious. Answering the following questions will give us a profile of the specific stresses - **past and present** - that you face, and help us assess any challenges to your health potential.

2. Addressing What Brought You To Our Center

Please briefly describe your chief concern, including the effect it has had on your life:

_____

_____

3. Health Concerns

LIST HEALTH CONCERNS IN ORDER OF IMPORTANCE	SEVERITY 1 = MILD 10 = UNBEARABLE	DATE THIS EPISODE STARTED	IF ONGOING, DATE OF LAST EPISODE	DID PROBLEM BEGIN WITH AN INURY?	ARE SYMPTOMS CONSTANT OR PERIODIC?
1.					
2.					
3.					

If you are experiencing pain, is it: ☐ Dull Ache ☐ Sharp

Does the pain radiate/travel anywhere? ☐ No ☐ Yes - please describe:

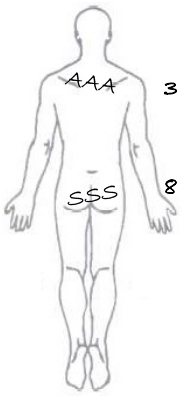
_____

4. Show Us Where It Hurts: Please mark **area(s)** of injury or discomfort as shown in the example below.
1. Mark all areas with the correct symbol. **2. Indicate** the degree of pain **from 1** (discomfort) to **10** (extreme pain).

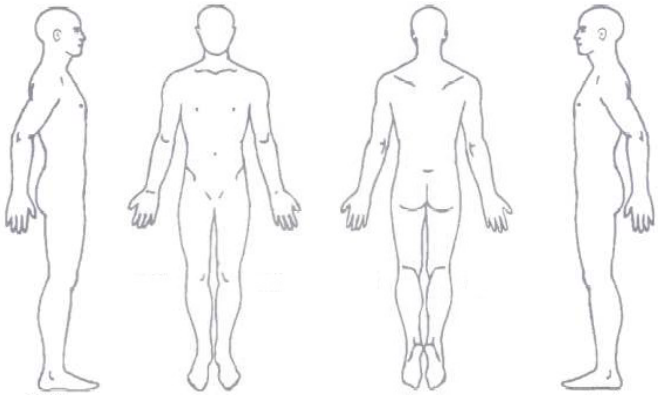
EXAMPLE

Numbness: **NNN**
Pins & Needles: **PPP**
Burning: **BBB**
Aching: **AAA**
Stabbing: **SSS**

☐ Circle any area(s) of pain not detailed with a symbol



Right **Front** **Back** **Left**



Since the problem started, it is: ☐ Getting Better ☐ About the Same ☐ Getting Worse

What makes it worse? _____

What have you done for this condition that has helped you feel better? _____

_____

What have you done that hasn't helped? _____

_____

☐ **I Do** ☐ **I Do Not** Have A Family History of this or similar symptoms (if you do, please explain)

_____

Is this condition interfering with your:

☐ Work ☐ Leisure ☐ Sleep ☐ Exercise / Fitness ☐ Attitude ☐ Hobbies ☐ Other _____

Have you thought of and/or felt the need to make any "positive" changes due to this condition?

(i.e. eat better, less alcohol/drugs, meditate, lower intensity exercise etc.) If "yes", what: _____

_____

Other Doctors Seen For This Condition: ☐ Chiropractor ☐ Medical Doctor ☐ Other

1. **Name/Address:** _____

   Date: _____ **What was the diagnosis?** _____

2. **Name/Address:** _____

   Date: _____ **What was the diagnosis?** _____

Who Is Your Family Doctor/Primary Care Physician?

Name/Address: _____

Date Of Last Check Up/Physical: _____ **Findings:** _____

III. General History

Please check all symptoms you have ever had, even if they do not seem related to you current problem:

☐ Headaches	☐ Pins & Needles in Legs	☐ Fainting	☐ Neck Pain
☐ Pins & Needles in Arms	☐ Back Pain	☐ Loss of Balance	☐ Sinus Infection
☐ Dizziness	☐ Ringing in Ears	☐ Frequent Colds/Flu	☐ Nervousness
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleep Problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Sensitivity to Light	☐ Urinary Problem	☐ Heartburn
☐ Mood Swings	☐ Menstrual Irregularity	☐ Menstrual Pain	☐ Ulcers

List any medications you are taking and why: (**prescription** and **non-prescription**) _____

_____

Please List All Surgeries Below:

1. Type: _____ Date: _____ Doctor: _____
2. Type: _____ Date: _____ Doctor: _____
3. Type: _____ Date: _____ Doctor: _____

Accidents and/or Injuries: auto, work related, or other (especially those related to your current problem):

1. Type: _____ Date: _____ Hospitalized ☐ Yes ☐ No
2. Type: _____ Date: _____ Hospitalized ☐ Yes ☐ No
3. Type: _____ Date: _____ Hospitalized ☐ Yes ☐ No

Have you ever had x-rays taken? ☐ No ☐ Yes (if "yes") Date: _____ Location: _____

Area(s) of body: _____

Please list your top 3 stresses in each category:

1. **Physical Stress** (falls, accidents, work posture, etc.)
   - A. _____
   - B. _____
   - C. _____

2. **Bio-Chemical Stress** (smoke, unhealthy foods, missed meals, lack of water, drugs, etc.)
   - A. _____
   - B. _____
   - C. _____

3. **Psychological Stress** (work, relationships, finances, self-esteem, etc.)
   - A. _____
   - B. _____
   - C. _____

IV. The Beginning Years (birth to 17 years)

Research is showing that many of the health challenges adults face started in the developmental years, often as early as birth. Please answer the following question as honestly and accurately as possible:

	Yes	No	Unsure
1. Did you have any serious childhood illnesses?	☐	☐	☐
2. Did you have any serious falls as a child?	☐	☐	☐
3. Did you play youth sports?	☐	☐	☐
4. Did you take/used any drugs (prescribed or not)?	☐	☐	☐
5. Did you have any surgery?	☐	☐	☐
6. Did you have any serious accidents?	☐	☐	☐
7. Did you have prolonged used of medications like antibiotics or inhalers?	☐	☐	☐
8. Did you suffer any other traumas physical or emotional?	☐	☐	☐
9. Were you vaccinated?	☐	☐	☐
10. Did you receive regular Chiropractic care?	☐	☐	☐

Comments: _____

_____

IV. Adult Years (18 years present)

	Yes	No
1. Do/did you smoke?	☐	☐
2. Do/did you drink alcohol (more than socially)?	☐	☐
3. Have you been in any accidents?	☐	☐
4. Have you had any surgery?	☐	☐
5. Do/did you play adult sports?	☐	☐
6. Do/did you play extreme sports?	☐	☐

On a scale of *1 to 10*, (*1) being very poor*, (*10) being excellent*, rate your:

Diet:	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Exercise:	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Sleep:	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Mind-set:	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Overall Health:	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Energy Level:	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

On a scale of *1 to 10*, (*1) being none*, (*10) being extreme*, rate your psychological/emotional stress levels:

Occupational:	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Personal:	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

V. Family Health Profile

At our center, we are interested in the health and well-being of your friends, family and loved ones, in addition to you. Please list their names and any health concerns they may have:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Others: _____

VI. Closing Notes

	Yes	No
1. Bought bottled water?	☐	☐
2. Belonged to a health club?	☐	☐
3. Taken vitamins or minerals?	☐	☐
4. If there is a need for dietary changes or nutrients, would you like to be informed?	☐	☐
5. If there is a need for specific exercises, would you like to be informed?	☐	☐
6. If there is a need for support in the psychological / mind / body / stress dimension of health, would you like to be informed?	☐	☐

I consent to a professional chiropractic examination and to any radiographic (x-ray) examination the doctor recommends. I understand that any fee for service(s) rendered is due at the time of service and cannot be deferred to a later date.

Printed Name: _____

Signature: _____ **Date:** _____

 [Note: **Only Complete Pages 5-7 If Yours Is An Accident Case** (i.e. Auto, Work, etc.). If You Need These Pages, Please Ask Us.]

Please Complete
Pages 6 and 7
Only If
You Had An Accident
(Auto, Work-Related, etc.)

Always Chiropractic & Wellness

Auto / Work-Related Accident - Page 1 of 2

1. About You

NAME: _____ **PATIENT #:**_____ **Today's Date:**_____

2a. Auto Related Accident

Date of Accident:_____ **Time of Accident:**_____ ☐ **a.m.** ☐ **p.m.** **# of people in vehicle:**_____

1. Did the police come to the accident site? ☐ Yes ☐ No
2. Was a police report filed? ☐ Yes ☐ No
3. Was a traffic violation issued? ☐ Yes ☐ No If "yes", to who?_____
4. Were there witnesses? ☐ Yes ☐ No
5. Were you surprised by the impact? ☐ Yes ☐ No
6. **About your vehicle:**
   1. Name of the location / street you were traveling on:_____
   2. Make / Model / Year: _____
   3. Direction were you heading: _____
   4. Estimated speed: _____
   5. Your vehicle was impacted in/at the: ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other
   6. During impact, you were facing: ☐ Right ☐ Left ☐ Forward ☐ Backward
   7. Were you wearing a seat belt? ☐ Yes ☐ No
   8. Did your vehicle have airbags? ☐ Yes ☐ No
      If "yes", did they inflate? ☐ Yes ☐ No
   9. In relation to the base of your skull, where was the headrest?
      ☐ Above ☐ Below ☐ At base of skull
   10. What did your vehicle impact? ☐ Another Vehicle ☐ Other:_____
   11. Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No
      If "yes", please explain: _____
7. **If another vehicle was involved:**
   1. Make / Model / Year: _____
   2. Direction traveling: _____
   3. Estimated speed: _____
8. Please describe the accident:_____

_____

_____

2b. Work Related Accident

Date of Accident:_____ **Time of Accident:**_____ ☐ **a.m.** ☐ **p.m.**

Was accident directly related to work? ☐ Yes ☐ No

1. Please describe the events immediately before and during the accident:_____

_____

2. Location/Address of accident:_____
3. Were there witnesses? ☐ Yes ☐ No Who?_____
4. Did you report accident to your employer? ☐ Yes ☐ No
5. What recommendations did your employer make immediately after you reported accident?_____

_____

6. Have you had this type of accident before? ☐ Yes ☐ No
7. To your knowledge, has this type of accident Ever happened in your workplace? ☐ Yes ☐ No
8. In general:
   1. Is you job physically stressful? ☐ Yes ☐ No
   2. Is your job mentally stressful? ☐ Yes ☐ No
   3. Is your workplace noisy? ☐ Yes ☐ No
9. Have you changed jobs in the past year? ☐ Yes ☐ No

Auto / Work-Related Accident - Page 2 of 2

3. After Injury

1. Were you ever unconscious? ☐ Yes ☐ No
   > If "yes", how long? _____
2. Describe how you felt immediately after the accident:
   _____
   _____
3. Have you seen any other doctor? ☐ Yes ☐ No
   > If "yes", how long after the accident?_____
   > How did you get there?_____
   > Name of Hospital:_____
   > Name & Type of Doctor:_____
4. Describe any treatment you have received:_____
   _____
5. Were x-rays taken? ☐ Yes ☐ No
6. Was medication prescribed? ☐ Yes ☐ No
7. Have you worked since this injury? ☐ Yes ☐ No
8. Are your work activities restricted? ☐ Yes ☐ No
9. Check the symptoms resulting from this accident:

☐ Dizziness	☐ Sleep issues	☐ Low back pain	☐ Back pain
☐ Memory loss	☐ Irritability	☐ Arm/Shoulder pain	☐ Nausea
☐ Headache(s)	☐ Fatigue	☐ Numb hands/fingers	☐ Chest pain
☐ Blurred vision	☐ Tension	☐ Upset stomach	☐ Leg pain
☐ Ringing ears	☐ Neck pain	☐ Shortness of breath	☐ Stiff neck
☐ Back stiffness		☐ Numb feet/toes	☐ Other

10. Your condition is:
    ☐ Stable ☐ Improving ☐ Worsening ☐ Varies
11. Rate your comfort level performing these activities:

	Comfortable	Uncomfortable	Painful
Lying on back	☐	☐	☐
Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Sex	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

12. Have you retained an attorney? ☐ Yes ☐ No
    If "yes": Name: asdadasdasd
    Phone#:_____

4. Recovery

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

1. How many hours do you work each day?_____
2. 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 Head
   ☐ Walking ☐ Crawling ☐ Typing
   ☐ Lifting ☐ Bending ☐ Stooping ☐ Other
3. What positions can you work in with minimum physical effort and for how long?_____ ☐ N/A
4. Prior to the injury, were you able to do the same work as other people your age? ☐ Yes ☐ No
5. Can anyone help you with lifting? ☐ Yes ☐ No
6. Can you request light duty in recovery? ☐ Yes ☐ No

5. Additional Insurance

2nd Insurance Source or Auto Insurance

Type of Insurance:_____
Insurance Company Name:_____
Address_____
City_____ ST_____ Zip_____
Phone_____ Claim #_____
Insured's Name_____
Policy #_____ Group#_____
Insured's SS #_____ D.O.B._____/_____/_____
Insured's Employer:_____
Insurance Agent's Name:_____

If any of your medical or account information has changed, please let us know.

Please know that you are ultimately responsible for payment of your account.

Signature_____ Date_____

OFFICE USE ONLY

_____
_____
_____
_____
_____