Welcome. Tell us about you.

Please complete all applicable items. You may attach additional pages or medication lists.

Full name

Today's date

Date of birth

Age

Preferred name

Street address

City

State

ZIP code

Best phone

Email

Occupation

Employer / retired

Emergency contact / relationship

Contact phone

Spouse / partner name

Phone

How did you hear about us?

Insurance identification: please bring your insurance / Medicare card to your visit.

OPTIONAL RECORDS RELEASE AUTHORIZATION

The supplied form permits release of copies of your record on your verbal request if you sign below. Otherwise, copies require your written authorization. Signing this optional section authorizes release of copies upon your verbal request.

Patient signature (optional)

Date

Symptoms & health concerns

Please complete all applicable items. You may attach additional pages or medication lists.

Full name **Date**

- ○ Foot pain
- ○ Neck pain
- ○ Diabetes
- ○ Pacemaker / defibrillator
- ○ Spinal stenosis
- ○ Leg pain
- ○ Chemotherapy
- ○ Arthritis in feet
- ○ Pinched nerve
- ○ Foot surgery
- ○ Hand pain
- ○ Foot numbness
- ○ High cholesterol
- ○ Herniated disc
- ○ Degenerative disc
- ○ Morton's neuroma
- ○ Cord / bladder stimulator
- ○ Plantar fasciitis
- ○ Poor circulation
- ○ Poor wound healing
- ○ Low back pain
- ○ Hand numbness
- ○ High blood pressure
- ○ Bulging disc
- ○ Vascular problems
- ○ Cancer
- ○ Arthritis in hands
- ○ Sciatica
- ○ Joint replacement
- ○ Excessive thirst / urination

YOUR PRIORITIES

1. Health concern **How long?**

2. Health concern **How long?**

3. Health concern **How long?**

4. Health concern **How long?**

Are symptoms better or worse at a certain time of day?

Is balance or walking affected? Please describe.

Your condition & previous care

Please complete all applicable items. You may attach additional pages or medication lists.

Full name **Date**

What have you tried? Select all that apply.

- ○ Gabapentin / Neurontin
- ○ Lyrica
- ○ Cymbalta
- ○ Physical therapy
- ○ Pain medication
- ○ Aleve
- ○ Tylenol
- ○ Ibuprofen / Motrin
- ○ Chiropractic
- ○ Massage therapy
- ○ Injections
- ○ Creams

Doctors you have seen and treatment received

What do you think is causing the problem?

- ○ Improved
- ○ Worsened
- ○ Stayed the same

What makes it worse?

What makes it better?

How would you describe your symptoms?

- ○ Aching
- ○ Stabbing
- ○ Sharp
- ○ Tiredness
- ○ Numbness
- ○ Tingling / electric shocks
- ○ Pins and needles
- ○ Heavy feeling
- ○ Hot sensation
- ○ Throbbing
- ○ Dead feeling
- ○ Cold hands / feet
- ○ Cramping
- ○ Swelling
- ○ Burning

Which activities are affected?

- ○ Sleep
- ○ Work
- ○ Daily activities
- ○ Recreation
- ○ Walking
- ○ Standing

Health history & daily habits

Please complete all applicable items. You may attach additional pages or medication lists.

Full name

Date

Primary care physician

Office phone

Physician office address

Last visit

May we send your physician updates on your condition / treatment?

- ○ Yes
- ○ No

Allergies / sensitivities: item and reaction

Prescription drugs: name, dose and times per day

Supplements: name, dose and times per day

Smoking: cigarettes per day / none

Alcohol: drinks per week / none

Exercise: type and frequency

Pain in the last week: 0 = no pain; 10 = worst possible pain

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

What pain level would you consider acceptable after treatment?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Quality of life

Please complete all applicable items. You may attach additional pages or medication lists.

Full name **Date**

Select all that apply. Your answers help us understand your experience and priorities.

1. HOW HAVE YOU CARED FOR YOUR HEALTH?

- ○ Medications
- ○ Exercise
- ○ Vitamins
- ○ Emergency room
- ○ Nutrition / diet
- ○ Chiropractic
- ○ Routine medical care
- ○ Holistic care
- ○ Other

2. HOW HAVE THOSE APPROACHES WORKED?

- ○ Bad results
- ○ Nothing changed
- ○ Still trying
- ○ Some results
- ○ Did not get worse
- ○ Confused
- ○ Great results
- ○ Did not work very long

3. HOW HAVE OTHERS BEEN AFFECTED?

- ○ No one is affected
- ○ They tell me to do something
- ○ Have not noticed a problem
- ○ People avoid me

4. WHAT ARE YOU CONCERNED THIS MAY AFFECT?

- ○ Job
- ○ Marriage
- ○ Time
- ○ Children
- ○ Self-esteem
- ○ Finances
- ○ Future ability
- ○ Sleep
- ○ Freedom

5. WHAT HEALTH CONDITIONS CONCERN YOU FOR THE FUTURE?

- ○ Family health problems
- ○ Diabetes
- ○ Depression
- ○ Heart disease
- ○ Arthritis
- ○ Chronic fatigue
- ○ Cancer
- ○ Fibromyalgia
- ○ Need for surgery

Other approaches or concerns you would like to discuss

Your goals & priorities

Please complete all applicable items. You may attach additional pages or medication lists.

Full name **Date**

6. How has this affected your job, relationships, finances, family or activities?

7. What has this cost you? Give three examples (time, money, sleep, freedom, etc.).

8. What concerns you most about your problem?

9. Where do you see yourself in 1-3 years if the problem is not addressed?

10. What would be different or better without this problem?

11. What do you most want from working with us?

12. What would that mean to you?

Wellness evaluation

Full name **Date**

Select symptoms you experience or conditions diagnosed by a practitioner. This evaluation guides discussion and does not establish a diagnosis or identify the cause of symptoms.

HEADACHES

- ○ Headaches
- ○ Migraines

HORMONAL CONCERNS

- ○ PMS
- ○ Emotional imbalance

GASTROINTESTINAL ISSUES

- ○ Abdominal bloating, cramps or painful gas
- ○ Irritable bowel syndrome
- ○ Ulcerative colitis
- ○ Crohn's / other intestinal disorders

RESPIRATORY CONDITIONS

- ○ Chronic sinusitis
- ○ Asthma
- ○ Allergies

JOINT CONCERNS

- ○ Knee, shoulder or spine

OTHER DIAGNOSED CONDITIONS

- ○ Diabetes mellitus
- ○ Lupus
- ○ Rheumatoid arthritis
- ○ Fibromyalgia
- ○ Chronic fatigue

THYROID CONDITIONS

- ○ Hashimoto's disease
- ○ Hypothyroidism
- ○ Hyperthyroidism

DEVELOPMENTAL / ATTENTION CONDITIONS

- ○ Autism
- ○ ADD / ADHD

SKIN CONDITIONS

- ○ Eczema
- ○ Skin rashes
- ○ Hives

SYMPTOM RATINGS - SELECT ONE RESPONSE PER ROW

Symptoms: 0 = none, 1 = mild, 2 = moderate, 3 = severe. Medication / antibiotic use: 0 = never, 1 = rarely, 2 = sometimes, 3 = often.

Constipation and/or diarrhea	○ 0 ○ 1 ○ 2 ○ 3		Asthma, hay fever or airborne allergies	○ 0 ○ 1 ○ 2 ○ 3	
Abdominal pain or bloating	○ 0 ○ 1 ○ 2 ○ 3		Confusion, poor memory or mood swings	○ 0 ○ 1 ○ 2 ○ 3	
Mucus or blood in stool	○ 0 ○ 1 ○ 2 ○ 3		Pain reliever use (aspirin, Tylenol, Motrin)	○ 0 ○ 1 ○ 2 ○ 3	
Joint pain / swelling or arthritis	○ 0 ○ 1 ○ 2 ○ 3		History of antibiotic use	○ 0 ○ 1 ○ 2 ○ 3	
Chronic or frequent fatigue / tiredness	○ 0 ○ 1 ○ 2 ○ 3		Alcohol consumption makes you feel sick	○ 0 ○ 1 ○ 2 ○ 3	
Food allergies / sensitivities / intolerance	○ 0 ○ 1 ○ 2 ○ 3		Gluten sensitivity or celiac disease	○ 0 ○ 1 ○ 2 ○ 3	
Sinus or nasal congestion	○ 0 ○ 1 ○ 2 ○ 3		Nausea	○ 0 ○ 1 ○ 2 ○ 3	
Chronic or frequent inflammation	○ 0 ○ 1 ○ 2 ○ 3		Weight concerns	○ 0 ○ 1 ○ 2 ○ 3	
Eczema, skin rashes or hives	○ 0 ○ 1 ○ 2 ○ 3				

Total (optional):

This total is not a diagnostic score and has no established cutoff in this form.

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