Discovery
WELLNESS CENTER

Date:_____

WELLNESS HEALTH HISTORY PROFILE

In order to provide you the best possible wellness care, please complete this form.
All information is strictly CONFIDENTIAL.

Name: _____ **DOB**: _____ **Age**: _____

Male / Female: _____ **Social Security #**: _____

Address: _____**City**: _____**State**: ____ **Zip**: _____

Home#: _____**Work#**: _____**Cell#**:_____

Best way to contact: ___ Home phone ____ Email ____ Cell ____ Text **Time to Call? AM** or **PM**

Email address*:_____**Status:** Single / Married / Divorced / Widowed

*Your email will not be shared with any third parties, and is used for occasional office announcements and promotions.

Occupation: _____ **Employer Name**: _____

Emergency Contact: _____ **Emergency Phone:**_____

Spouses Name: _____ **Number of Children**: _____

Who may we thank for referring you to our office? _____

Reception Will Need To Make a Copy of Your Insurance Cards to Keep On File

Nature of Injury: ☐ AUTO ☐ WORK ☐ HOME

Date of Injury:_____ Date symptoms appeared:_____

Please describe: _____

_____

Name of party responsible for payment:_____ Phone:_____

Do you have health insurance? ☐ NO ☐ YES Name of company: _____

If an auto accident, please provide: Insurance Company Name: _____

Contact Person: _____ Phone: _____ Claim #: _____

Name of the Insured:_____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient signature:_____ Date:_____

YOUR HEALTH PROFILE

What brings you into our office today?
Please briefly describe, including the impact it has had on your life.

Rate Severity (scale 1-10, 1 being mild) When and how did this start? Are symptoms constant or intermittent?

Since the problem started it is; ___the same ___getting better ___ getting worse
What makes the problem worse? _____

What, if anything, makes the problem feel better?_____

Does this interfere with your; ___Leisure ___Work ___Sleep ___Sports ___Other

Have you ever had same condition? ☐ NO ☐ YES If yes, when? _____

Have you seen other doctors for this condition? ___Chiropractor ___MD ___Other

Name/Address: _____Date: _____

What was the diagnosis? _____

GENERAL HISTORY

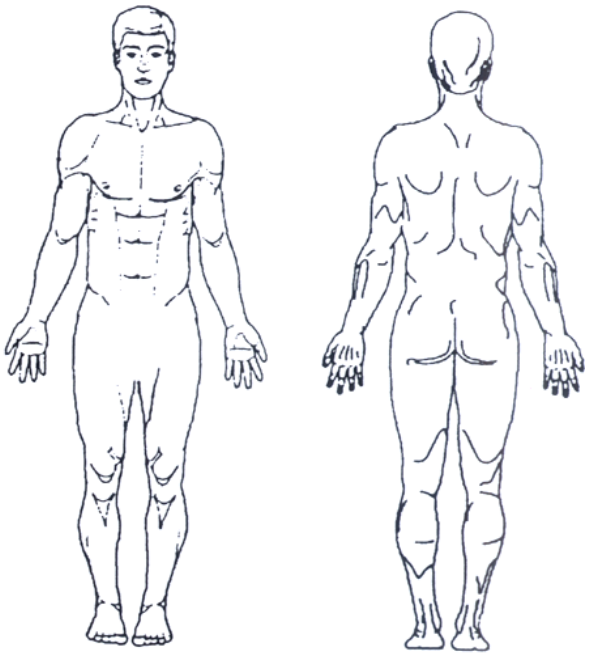
Please list all medications you are taking, and why; (Prescription and non-prescription)

Have you had any surgeries and/or hospitalizations? ☐ NO ☐ YES
If yes, briefly explain: _____

Have you ever had any work related injuries? ☐ NO ☐ YES
If yes, briefly explain:_____

Have you ever had any slips, falls or auto accidents? ☐ NO ☐ YES
If yes, briefly explain:_____

Please indicate where your complaint is on the following diagram:



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

- ☐ Headaches
- ☐ Neck Pain
- ☐ Pins & needles in arms
- ☐ Pins & needles in legs
- ☐ Dizziness
- ☐ Numbness in fingers
- ☐ Fatigue
- ☐ Sleeping problems
- ☐ Tension
- ☐ Ulcers
- ☐ Irritability
- ☐ Stomach upset
- ☐ Cold sweats
- ☐ Back pain
- ☐ Fever
- ☐ Mood Swings
- ☐ Eyes bothered by light
- ☐ Buzzing in ears
- ☐ Stiff neck
- ☐ Ringing in ears
- ☐ Numbness in toes
- ☐ Depression
- ☐ Constipation
- ☐ Menstrual pain
- ☐ Menstrual irregularity
- ☐ Hot flashes
- ☐ Cold hands
- ☐ Cold feet
- ☐ Diarrhea
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Urinary problem
- ☐ Nausea
- ☐ Fainting

YOUR GOALS

On a scale of 1 to 10 (10 being extreme), describe your emotional/psychological/lifestyle stress levels:

Scale =____ Occupational stress: _____

Scale =____ Personal stress: _____

On a scale of 1 to 10 (10 being excellent), describe your habits and condition as it relates to:

Eating_____ Exercise_____ Sleep_____ General Health_____ Wellness lifestyle_____

Were concerned about your health & wellness goals, please take a moment to list your goals.

Wellness Goals		
Be Fit (*Physical*)	**Eat Right** (*Nutritional*)	**Think Well** (*Psychological*)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Thank you for filling out this form. It is your first step to Creating Wellness!

I consent to a professional and complete chiropractic examination, and to any radiographic examination that the doctor deems necessary. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date.

Signature: _____ Date: _____

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