NORTHWEST WELLNESS CENTER

NEW PATIENT INFORMATION

WHOM MAY WE THANK FOR REFFERING YOU TO OUR OFFICE: ____________________________ **TODAY'S DATE:** ______________

PATIENT DEMOGRAPHICS:

Name: ____
Birth Date: _____-_____-_____ Age: ________ ❑ M ❑ F
Address: ____
City: _____________________State: _______ Zip: _______
Social Security:___________________________________
Email: ____
Mobile #: ____
Occupation: ______________________________________

Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced ❑Engaged
Name of Spouse: ____
Occupation: ____
Mobile#: ____
How many children do you have :______________________________
Emergency Contact:____
Relationship: ___________________Phone#:____________________

INSURANCE INFORMATION:

Do you have Medicare? ❑ Yes ❑ No

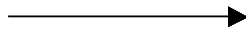
If yes, do you have secondary insurance? ❑ Yes ❑ No

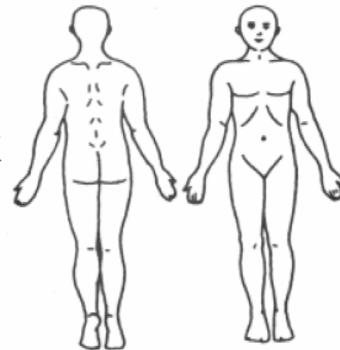
HISTORY OF COMPLAINT:

1. Please identify the condition(s) that brought you to our office:
   1st: ________________________________ 2nd: ________________________________ 3rd: ______________________________
2. On a scale of 0-10 (0 = no pain and 10 = worst pain), rate your above complaints, by checking the number **THAT APPLIES**:
   1st : ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
   2nd: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
   3rd : ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
3. When did the complaint(s) begin? ________________________ When is the complaint(s) the worst? ❑ AM ❑ Mid-Day ❑ PM
4. How did the "injury" (complaint) happen? ____
5. How long does it last? ❑ It is constant ❑ I experience it on and off during the day ❑ It comes and goes throughout the week

DESCRIBE YOUR SYMPTOMS:

PLEASE MARK the areas on the diagram with the following LETTERS:
R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness
S = Sharp/Stabbing **T** = Tingling





PAST HISTORY:

1. Have you suffered with this or a similar problem in the past? ❑ No ❑ Yes – If yes, How many times? ______________________
   When was the last episode? ______________________ How did the injury happen? ____________________________________
2. Other forms of treatment tried? ❑ No ❑ Yes – If yes, please state what type of treatment: ______________________________
   and who provided treatment: ___________________________________ How long ago? _________________________________
   What were the results? ❑ Favorable ❑ Unfavorable – Please explain: ____
3. Have you ever seen a chiropractor? ❑ No ❑ Yes – If yes, what were the results? ❑ Bad ❑ Good ❑ Great

ACTIVITIES OF DAILY LIVING:

1. No effect 3. Painful (activities limited)
2. Painful (can do) 4. Unable to perform

Activity				
Bending	❑ 1	❑ 2	❑ 3	❑ 4
Carrying	❑ 1	❑ 2	❑ 3	❑ 4
Climbing	❑ 1	❑ 2	❑ 3	❑ 4
Computer work	❑ 1	❑ 2	❑ 3	❑ 4
Concentrating	❑ 1	❑ 2	❑ 3	❑ 4
Dancing	❑ 1	❑ 2	❑ 3	❑ 4
Doing Chores	❑ 1	❑ 2	❑ 3	❑ 4
Dressing	❑ 1	❑ 2	❑ 3	❑ 4
Driving	❑ 1	❑ 2	❑ 3	❑ 4
Gardening	❑ 1	❑ 2	❑ 3	❑ 4
Lifting	❑ 1	❑ 2	❑ 3	❑ 4
Playing Sports	❑ 1	❑ 2	❑ 3	❑ 4
Pushing	❑ 1	❑ 2	❑ 3	❑ 4
Reading	❑ 1	❑ 2	❑ 3	❑ 4
Recreational Activities	❑ 1	❑ 2	❑ 3	❑ 4
Rolling Over	❑ 1	❑ 2	❑ 3	❑ 4
Running	❑ 1	❑ 2	❑ 3	❑ 4
Sexual Activity	❑ 1	❑ 2	❑ 3	❑ 4
Shoveling	❑ 1	❑ 2	❑ 3	❑ 4
Sitting	❑ 1	❑ 2	❑ 3	❑ 4
Sitting to Standing	❑ 1	❑ 2	❑ 3	❑ 4
Sleeping	❑ 1	❑ 2	❑ 3	❑ 4
Standing	❑ 1	❑ 2	❑ 3	❑ 4
Walking	❑ 1	❑ 2	❑ 3	❑ 4
Watching TV	❑ 1	❑ 2	❑ 3	❑ 4
Working	❑ 1	❑ 2	❑ 3	❑ 4

SYMPTOMS:

Please check all that apply in **past 12 months.**

- ❑ ADD/ADHD
- ❑ Allergies
- ❑ Arthritis
- ❑ Asthma
- ❑ Bed Wetting
- ❑ Blood Pressure (High or Low)
- ❑ Blurred Vision
- ❑ Broken Bones/Fractures
- ❑ Cancer
- ❑ Colon Trouble/Digestive Issues
- ❑ Depression
- ❑ Diarrhea/Constipation
- ❑ Difficulty Breathing
- ❑ Dizziness/Loss of Balance
- ❑ Double Vision
- ❑ Eating Disorder
- ❑ Epilepsy/Convulsions
- ❑ Fainting
- ❑ Foot or Knee Problems
- ❑ Frequent Colds/Flu
- ❑ Gall Bladder Trouble
- ❑ Headaches
- ❑ Hearing Loss
- ❑ Heartburn
- ❑ Heart Problem
- ❑ Hepatitis (A,B,C)
- ❑ Hormone Imbalance
- ❑ Impotence/Sexual Dysfunction
- ❑ Irritable
- ❑ Jaw pain/TMJ
- ❑ Kidney Trouble
- ❑ Learning Disability
- ❑ Liver Trouble
- ❑ Lung Problems
- ❑ Menopausal Problems
- ❑ Mood Changes
- ❑ Numb/Tingling arms, hands, fingers
- ❑ Numb/Tingling legs, feet, toes
- ❑ Osteoporosis
- ❑ Pain CHEST
- ❑ Pain HIP
- ❑ Pain LOW BACK
- ❑ Pain MID BACK
- ❑ Pain NECK
- ❑ Pain SHOULDER
- ❑ Pain UPPER BACK
- ❑ Painful Swollen joints
- ❑ Pregnant (now)
- ❑ Prostate Problems
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Sinus/Drainage Problem
- ❑ Skin Problems
- ❑ Swollen/Painful Joints
- ❑ Tremors
- ❑ Trouble Sleeping
- ❑ Tumors
- ❑ Ulcers

ARE YOU TAKING MEDICATIONS FOR ANY OF THE FOLLOWING:

❑ Acid Reflux	❑ Anxiety	❑ Cholesterol	❑ Hormone Therapy (HRT)	❑ Thyroid
❑ ADD/ADHD	❑ Aspirin	❑ Crohns/Colitis	❑ Ibuprofen	❑ Tylenol
❑ Allergy	❑ Birth Control	❑ CPAP machine	❑ Muscle Relaxer	❑ _________________
❑ Anti-biotics	❑ Blood Pressure	❑ Diabetes	❑ Pain Killer	❑ _________________
❑ Antidepressants	❑ Blood Thinner	❑ Headache	❑ Sleep	❑ _________________

FAMILY HISTORY:

1. Does anyone in your family suffer with the same complaint(s)? ❑ No ❑ Yes
   If Yes, whom? ❑ Grandmother ❑ Grandfather ❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son
2. Have they ever been treated for the same condition(s)? ❑ No ❑ Yes ❑ I don't know
3. Any other hereditary conditions the Doctor should be aware of? ❑ No ❑ Yes: If yes, Explain: _______________________________

SOCIAL HISTORY:

1. Smoking: ❑ Cigars ❑ Pipe ❑ Cigarettes >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverages (Consumption): >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug Use: >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. How does your present complaint affect your recreational activities/exercise regime/hobbies? _______________________________
   ____

PHYSICAL STRESS:

1. Have you ever been in a car accident? ❑ No ❑ Yes - If yes when? ____
   a. What speed was the collision? ❑ 0 - 10 ❑ 10 - 20 ❑ 20 - 30 ❑ 40 - 50 ❑ 50+
   b. Type of impact: ❑ Front Impact ❑ Side Impact ❑ Rear Impact ❑ Roll-Over
   c. Was treatment received? ❑ No ❑ Yes – If yes, explain: ____
2. Have you ever been injured at work? ❑ No ❑ Yes – If yes, explain: ____
   a. Was treatment received? ❑ No ❑ Yes – If yes, explain: ____
   b. Does your job require you to remain in long-term stressful postures? ❑ No ❑ Yes
      (*i.e. all day seating, repeated lifting, long-term computer use)*
3. Have you ever had any spinal traumas in the past? ❑ No ❑ Yes – If yes, explain: ____
   a. Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field (explain) :____
   b. Trauma as a child: fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident, sports injury (explain):____
   c. Work around the house: (lifting, bending, woke up with stiff neck, "back went out") (explain):
      ____

STRESS PROFILE:

1. How many hours of sleep do you average per night? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑7 ❑ 8 ❑ 9 ❑ 10+
2. Do you have trouble falling asleep ❑ Wake up and can't fall back asleep ❑ Wake up exhausted like you never slept ❑
3. Do you ever take pills to go to sleep or relax? ❑ No ❑ Yes
4. Do you use a CPAP machine? ❑ No ❑ Yes
5. Do you often feel short on time and procrastinate on projects? ❑ No ❑ Yes
6. Do you feel like you don't give enough time to important areas in your life like family, personal , or a hobby? ❑ No ❑ Yes

CHEMICAL STRESS PROFILE:

1. Are you regularly exposed to cleaning products or industrial chemicals? ❑ No ❑ Yes
2. Have you ever noticed mold growing in your home or your place of work? ❑ No ❑ Yes
3. Does your home, work, school, or car have damp or mildew smell? ❑ No ❑ Yes

FITNESS PROFILE:

1. What type of exercise do you practice? ❑ Cardio ❑ Weight training ❑ Yoga ❑ Burst ❑ Organized sports ❑ Triathlons
2. Where do you workout? ❑ Gym ❑ Home ❑ Group Class ❑ Don't workout
3. How long do you exercise Minutes ❑ 0-30 ❑ 30-60 ❑ 60-90 ❑ 90+
4. How often do you exercise Days per Week ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
5. What is your goal? ❑ Weight ❑ Muscle ❑ Fitness ❑ Energy ❑ Image
6. What is your current weight? ____________ What is your target weight? ___________

NUTRITIONAL PROFILE:

1. Do you eat breakfast daily from Monday to Friday? ❑ No ❑ Yes
2. How many days per week do you skip one meal? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
3. How many fast food, refined foods, or pre-pared meals do you eat per week? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
4. How many servings of fruit do you have on a given day? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
5. How many servings of vegetables do you have on a given day? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
6. Do you regularly drink (1 or more per day) ? (check all that apply) ❑ Soda ❑ Coffee ❑ Juice ❑ Milk ❑ Alcohol
7. Please list any supplements you take regularly: ____

   ____
8. Please list any allergies or sensitivities: ____

WHAT DO YOU FOCUS ON WHEN SELECTING FOODS?

(check all the apply):

- ❑ Calorie Content
- ❑ Fat Content (low fat diet)
- ❑ Ingredient list
- ❑ Sodium levels
- ❑ Artificial Sweeteners
- ❑ Ratio: Fat, Protein, Sugar
- ❑ Fat content (low fat)
- ❑ Nutrition data label
- ❑ Gluten content
- ❑ Pasteurization (milk)
- ❑ Glycemic Index
- ❑ Sugar content
- ❑ MSG content
- ❑ FDA food pyramid

WHAT TYPE OF FOOD DO YOU BUY?

(check all the apply):

- ❑ Organic Vegetables
- ❑ Grass-fed beef
- ❑ Wild-caught fish
- ❑ Non-GMO food
- ❑ Wild/Free range poultry
- ❑ Fresh fruit
- ❑ Healthy snacks
- ❑ Almond/coconut milk
- ❑ Water
- ❑ Regular Vegetables
- ❑ Grain-fed beef
- ❑ Farm raised fish
- ❑ GMO food/don't know
- ❑ Unknown source of poultry
- ❑ Canned Preserved fruit
- ❑ Junk food snacks
- ❑ Cow/soy milk
- ❑ Soda/Sweet tea/Coffee

DO YOU FOLLOW A NAMED DIET OR DOCTOR'S PLAN?

(check all the apply):

- ❑ Blood Type
- ❑ GAPS
- ❑ Paleo
- ❑ Raw Food
- ❑ Vegetarian
- ❑ Zone Diet
- ❑ Other _______________
- ❑ Atkins
- ❑ Mediterranean
- ❑ Nutrisystem
- ❑ South Beach
- ❑ Volumetrics
- ❑ Weight Watchers
- ❑ None

WHAT DO YOU TYPICALLY EAT FOR BREAKFAST?

(check all the apply):

- ❑ Eggs
- ❑ Fruit
- ❑ Smoothie
- ❑ Vegetables
- ❑ Vegetarian
- ❑ Other___________________
- ❑ Cereal
- ❑ Oatmeal
- ❑ Packaged meats
- ❑ Pastries
- ❑ Toast
- ❑ Other_______________

ANY ADDITIONAL INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW?

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