NEW CLIENT INFORMATION

Today's Date_____

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Nickname or preferred name: _____

Home / Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

email address: _____

Occupation: _____ Employer / School: _____

Work Phone: (_____) _____ Work Status: ☐Full-time ☐Part-time ☐Seasonal ☐Other

In case of an Emergency – Contact: _____ Relationship: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Marital Status: ☐S ☐M ☐D ☐W ☐ Other _____ Number of Children *(if any)* & ages: _____

Most of our patients are referred to us by a caring family or friend. Whom may we thank for referring you to our office? Or how did you hear about us? _____

Do you have a Primary Care Physician? ☐Y ☐N Would you like Functional Wellness to provide progress reports or information to your PCP or other practitioners? *If yes*: Full Name of Practitioner _____

HEALTH INFORMATION

***HEALTH CONCERNS*:** Please list your top health concerns / complaints that you would like to address (in order of priority):

1) _____

2) _____

3) _____

Is this concern affecting your quality of life? (Please circle only those applicable to you)

Work / School:	Y	N	Recreation:	Y	N	Sleep:	Y	N
Exercise / sports:	Y	N	Walking:	Y	N	Sitting:	Y	N
Eating:	Y	N	Intimate/Personal Life:	Y	N	Other:	Y	N

HEALTH CARE PRACTITIONER HISTORY:

Have you ever received Chiropractic care? ☐Y ☐N When: _____

Where: _____ Doctor(s) name(s): _____

How long under care: _____ Date of last visit: _____ Why did you stop? _____

Was there a particular health concern(s) for which you consulted the chiropractor? _____

Did you find the treatments helpful?_____

Have you consulted or do you regularly consult any of the following care providers? *(check all that apply)*

☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐Homeopath

☐ Massage Therapist ☐ Psychotherapist ☐ Physical Therapist ☐Dentist

☐ Nutritionist ☐ Personal Trainer ☐ Other: _____

Comments (conditions, treatments, success, etc.) _____

_____

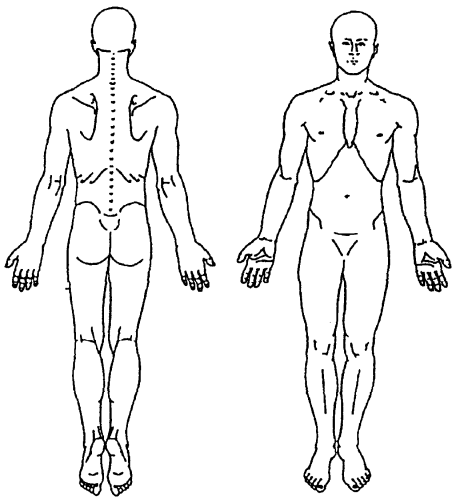
_____

MEDICAL HISTORY: – Please check all that apply (**P** = Past / **C** = Current):

P / C	P / C	P / C
···· Abdominal Pains	···· Frequent Urination	···· Rapid Heart Rate
···· Ankle/Foot Pain	···· Fullness of Bladder	···· Shakiness
···· Blurred Vision	···· Headache	···· Shoulder Pain
···· Chest Pressure	···· Hemorrhoids	···· Sinusitis
···· Clammy Hands	···· High Blood Pressure	···· Slow Heart Rate
···· Confusion	···· Hip Pain	···· Sore Muscles
···· Constipation	···· Insomnia	···· Sore Throat
···· Convulsions	···· Irritability	···· Swallowing Pain
···· Decreased Sex Drive	···· Joint Stiffness	···· Sweating
···· Dizziness	···· Knee Pain	···· Swollen Ankles
···· Dry Mouth	···· Low Back Pain	···· Swollen Joints
···· Earache	···· Low Blood Pressure	···· Teeth Grinding
···· Elbow/Hand Pain	···· Lump in Throat	···· Tingling in Feet
···· Excessive Thirst	···· Menstrual Irregularities	···· Tingling in Hands
···· Eye Pain	···· Nausea/Vomiting	···· Urination Difficulty
···· Facial Pain	···· Neck Pain	···· Walking Problems
···· Fainting	···· Paralysis	···· Weak Muscles
···· Fatigue	···· Persistent Coughing	···· Other:_____
···· Feel Loss of Control	···· Poor Appetite	_____
···· Forgetfulness	···· Poor Circulation	_____

Please use the legend below to indicate any areas in which you feel the listed sensations

Stabbing - ||| **Tingling - :::**
Burning – XXX **Cramping - ^^^**
Numbness - === **Dull / Ache - ###**



***Women only*: # of pregnancies: _____** # of birth children: _____ # of C-Sections: _____

Age of children (if any): _____ Breast fed? ☐Y ☐N How long (each child) ? _____

Age of menarche (periods began): _____ Are you experiencing perimenopause? ☐Y/☐N Reached Menopause ☐Y/☐N

Is there any chance you might be pregnant? ☐Y ☐N Date of last menstrual cycle: _____

Do you currently, or have you used any of the following? (please circle all that apply) Birth Control Pills, Hormone Replacement Therapy, Hormone IUD, Copper IUD, Contraceptive Shot (ex. Depo), Vaginal Ring, Contraceptive Patch, Emergency Contraceptive

Length of use of each type? _____ Have you ever had an abnormal PAP? ☐Y ☐N

HEALTH & FAMILY HISTORY:

Height:_____ Weight:_____ Recent Weight Loss / Gain? _____

Reason / method for weight loss / gain: _____

Difficulty falling asleep? ☐Y ☐N Difficulty staying asleep? ☐Y ☐N Tired after full night's sleep? ☐Y ☐N

Crave sugar / salt? ¨ ☐Y ☐N Fatigue after meals? ☐Y ☐N Lightheaded / irritable when hungry?☐Y ☐N

Need coffee / sweets 3-4pm? ☐Y ☐N Do you eat Breakfast? ☐Y ☐N Usual breakfast foods:_____

What time do you eat Breakfast? _____ What time do you eat Lunch? _____

What time do you eat Dinner? _____ Do you eat snacks? ¨Y/¨N Types:_____

Identify any conditions that **you**, or any of **your family members** have now or have had in the past:

(**X** = Self, **G** = Grandparents, **M** = Mother, **F** = Father, **S** = Siblings)

___Alcoholism	___Eczema/Psoriasis	___Hepatitis A/B/C	___Stroke
___Anemia	___Emphysema	___Herpes	___Tumor(s)
___Cancer	___Epilepsy	___High Blood Pressure	___Ulcer(s)
___Cold sores	___Goiter	___Mumps	Other: _____
___Deep vein thrombosis	___Gout	___Pleurisy	_____
___Depression/Anxiety	___Heart disease	___Pneumonia	_____
___Diabetes	___HIV/AIDS	___Polio	

Do you wear corrective lenses? ¨Y ¨N Date of last check-up / prescription change? _____

Physical, chemical, structural and emotional stresses, common to our contemporary lifestyles, can result in dysfunction of the areas surrounding and involving the nervous system (the body's primary system which co-ordinates health}. The following may be seemingly insignificant events, however they may be contributing to today's experiences of health and wellbeing. Please feel free to add anything not listed here, and to ask any questions you may have regarding this section.

ACCIDENTS: Have you had any accidents related to any of the following? (check all that apply)

☐Automobile ☐Motorcycle ☐Bicycle ☐Sports ☐Playground ☐Abuse ☐Other

Year ***(approximate)***	**Please describe** ***(injuries, treatment, outcome)***

INJURIES: Have you ever injured any of the following regions? (check all that apply)

☐Head ☐Neck ☐Rib/Chest ☐Back ☐Pelvis/Hip ☐Arm/Hand ☐Leg/Foot

Year ***(approximate)***	**Please describe** ***(injuries, treatment, outcome)***

HOSPITALIZATIONS / SURGERIES: Please detail any hospitalizations, serious illnesses or surgeries

Year	**Reason**	**Hospital**	**Outcome**

MEDICATIONS: Please list all medications you are currently taking (prescribed or over-the-counter)

Medication Name	**Condition**	**Date Started**	**Who Prescribed?**

NUTRITIONAL SUPPLEMENTS: Please list all Vitamins and Nutritional supplements you are currently taking

Supplement	Brand and Amount Consumed	Date Started	Prescribed by anyone?

ALLERGIES: Please check and list all allergies

☐ Food: _____

☐ Medications: _____

☐ Seasonal/Latex/Other: _____

HABITS: Please include current and previous amounts

	Daily	Weekly	Monthly	Never
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda/Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Rec. Drugs	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Exercise	☐	☐	☐	☐	_____	
	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs	
Sleep	☐	☐	☐	☐	☐	
	5+	4	3	2		
Meals/day	☐	☐	☐	☐		
	8+ cups	4-7 cups	2-4 cups	<8 oz		
Water/day	☐	☐	☐	☐		

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐Walking/Moving ☐Driving

STRESS LEVEL: ☐ Very High ☐ High ☐ Medium ☐ Low

Have you traveled in the last six to twelve months? ☐Y ☐N If yes: Where, for how long? _____

_____

If you have any concerns or questions you would like to note here, or issues you think might be related to your condition please do not hesitate to discuss any matter with Dr. Slavin prior to, during or after your appointment.

_____

_____

_____ _____ _____

Patient Name Printed Patient Signature Date

_____ _____

Parent and/or Guardian Printed Parent and/or Guardian Signature