

NAME:		DATE	·
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE: ()	CELL PHONE: ()	DOB:	AGE:
REFERRED BY:			
OCCUPATION:	EMPLOYER:		
EMAIL:			
MARITAL STATUS: S M	D W SPOUSE'S NAME		
PERSON TO CONTACT IN CASE	E OF EMERGENCY:		
PHONE:	RELATION:		
DO YOU RECALL GETTING BIT	NOTICING SYMPTOMS? BY A TIC	CK/SPIDER/OTHER:	
DO YOU RECALL GETTING A F	RASH OR BULLSEYE MARK?		
	LIST OF SYMPTOMS:		

For office use only. ROF Date:

ONLY Answer Applicable Questions

Signature

Name		
Date of Birth		
Date		

Medical History Please be specific with you answers

***Use PAIN SCALE at the bottom of page to rate any pain questions.

Headaches / Sinuses / Location of pain Visual changes / Lights / Hoaters / Pain Headring / Loss / Ringing / Tules Speech / Dyslexia / Etc. Memory Facial Drooping / Numbness Facial Dr	How has you health changed since your last visit (if yo	ou have been seen be	efore?)				
Visual changes / Lights / Floaters / Pain Hearing / Loss / Ringing / Tubes Speech / Dyslexia / Etc. Memory Facial Drooping / Numbness Faigue Level Do you need assistance with daily activities? Are you able to work (of employed)? Presently, are you disabled? Trasts / Smell Appetite / Special diet Do you take Supplements? (List) Lacitoes Intolerant / Gluten Boy over the Supplements? (List) Lacitoes Intolerant / Gluten Boy over the Supplements? (List) Lacitoes Intolerant / Gluten Boy over the Supplements over	Handachas / Sinusas / Location of pain						
Hearing / Loss / Ringing / Tubes	Visual changes / Lights / Floaters / Pain						
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Depression / Anxiety / Irritable							
Do you see a Counselor / Psychiatrist?							
Joint pain / swelling (be specific)	Depression / Anxiety / Irritable						
Muscle pain	Do you see a Counselor / Psychiatrist?						
Muscle twitching (fasciculation)							
Do you have any joint deformities?							
What medication help you?							
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\odot WEALTH OF WELLNESS CHIROPRACTIC \odot

WELLNESS CONSULT

NAME:	DATE:		!
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE: ()	CELL PHONE: ()	DOB:	AGE:_
REFERRED BY:			
OCCUPATION:	EMPLOYER:		
EMAIL:			
MARITAL STATUS: S M	D W SPOUSE'S NAME		
PERSON TO CONTACT IN CAS	E OF EMERGENCY:		
PHONE:	RELATION:		
	LIST OF SYMPTOMS:		
MILD:			
MODERATE:			
SEVERE:			
			-
HOW LONG HAVE YOU BEEN	NOTICING SYMPTOMS?		

ANY ADDITIONAL INFORMATION:



NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG' is defined to mean:

"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A Vitamin, Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy is not a drug.

Although, a Vitamin, Mineral, Trace Element, Amino Acid, or Herb may have an effect on disease processes or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advise is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling and advice on vitamin supplements are provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Thank You for your trust!	
I have read and understand the above:	
Signature	Date