

☺WEALTH OF WELLNESS CHIROPRACTIC ☺  
LYME 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 CASE OF EMERGENCY: \_\_\_\_\_

PHONE: \_\_\_\_\_ RELATION: \_\_\_\_\_

HAVE YOU BEEN PREVIOUSLY TESTED FOR LYME DISEASE? Y N BY WHOM? \_\_\_\_\_

HOW LONG HAVE YOU BEEN NOTICING SYMPTOMS? \_\_\_\_\_

DO YOU RECALL GETTING BIT ? \_\_\_\_\_ BY A TICK/SPIDER/OTHER: \_\_\_\_\_

DO YOU RECALL GETTING A RASH OR BULLSEYE MARK? \_\_\_\_\_

LIST OF SYMPTOMS:

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For office use only.

ROF Date:

**ONLY Answer Applicable Questions**

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Date \_\_\_\_\_

**Medical History Please be specific with you answers**

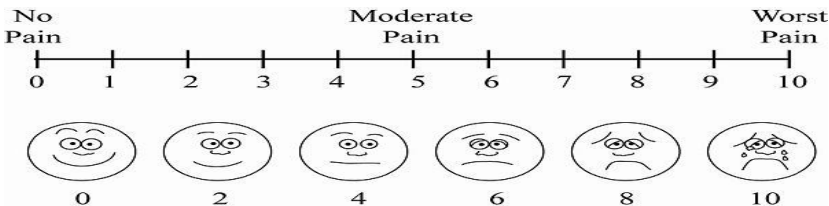
**\*\*\*Use PAIN SCALE at the bottom of page to rate any pain questions.**

How has you health changed since your last visit (... if you have been seen before?) \_\_\_\_\_  
Headaches / Sinuses / Location of pain \_\_\_\_\_  
Visual changes / Lights / Floaters / Pain \_\_\_\_\_  
Hearing / Loss / Ringing / Tubes \_\_\_\_\_  
Speech / Dyslexia / Etc. \_\_\_\_\_  
Memory \_\_\_\_\_  
Facial Drooping / Numbness \_\_\_\_\_  
Fatigue Level \_\_\_\_\_  
Do you need assistance with daily activities? \_\_\_\_\_  
Are you able to work (if employed)? \_\_\_\_\_  
Presently, are you disabled? \_\_\_\_\_  
Taste / Smell \_\_\_\_\_  
Appetite / Special diet \_\_\_\_\_  
Do you take Supplements? (List) \_\_\_\_\_  
Lactose Intolerant / Gluten \_\_\_\_\_  
Body temperature changes \_\_\_\_\_  
Does weather change bother you? \_\_\_\_\_  
Hair loss / Sores \_\_\_\_\_  
Swallowing problems \_\_\_\_\_  
Tongue / Throat / Glands \_\_\_\_\_  
Dry eyes (rate to what degree) \_\_\_\_\_  
Writing changes \_\_\_\_\_  
Driving Skills \_\_\_\_\_  
Coordination / Walking devices \_\_\_\_\_  
Tremors / Seizures \_\_\_\_\_  
Any type of rashes \_\_\_\_\_  
Chest Pain / SOB / Cough \_\_\_\_\_  
Irregular heart beats \_\_\_\_\_  
Ever had an abnormal EKG \_\_\_\_\_  
Nausea / Vomiting / Heartburn \_\_\_\_\_  
Diarrhea / Constipation/ Abdominal Pain \_\_\_\_\_  
Use of regular laxatives? \_\_\_\_\_  
Unusual weight gain or loss \_\_\_\_\_  
Breast problems \_\_\_\_\_  
Bladder / Pain / Frequency \_\_\_\_\_  
Menstrual / Vaginal Changes \_\_\_\_\_  
Testical / Prostate \_\_\_\_\_  
Testical pain \_\_\_\_\_  
Loss of Libido \_\_\_\_\_  
Sleeping problems / napping \_\_\_\_\_  
Depression / Anxiety / Irritable \_\_\_\_\_  
Do you see a Counselor / Psychiatrist? \_\_\_\_\_  
Joint pain / swelling (be specific) \_\_\_\_\_  
Muscle pain \_\_\_\_\_  
Muscle twitching (fasciculation) \_\_\_\_\_  
Do you have any joint deformities? \_\_\_\_\_  
What medication help you? \_\_\_\_\_  
Other symptoms not mentioned \_\_\_\_\_

Are you thinking of applying for disability? \_\_\_\_\_

Have you discontinued any meds since last seen? \_\_\_\_\_

Signature \_\_\_\_\_



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LIST OF SYMPTOMS:

MILD:

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MODERATE:

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SEVERE:

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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: \_\_\_\_\_