WELLNESS CONNECTION

NEW PATIENT APPLICATION AND CASE HISTORY

Today's Date _____

Name _____ Age _____ Sex: ☐ M ☐ F DOB _____ SSN _____-_____-_____

Address _____ City_____ State _____ Zip _____

Cell Phone _____ Work Phone _____ E-mail: _____

May we leave a voice mail: ☐ Height _____ Weight: _____

How Did You Hear About Us? _____

Employer: _____ Occupation: _____ Length of Employment: _____

Present Complaints

1. Main Problem(s): _____

_____

_____

2. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and your own opinion what do you think the real problem is : _____

_____

_____

3. When did you become aware of your condition:

_____

_____

What diagnostic tools were used to achieve your diagnosis of your condition:

_____

_____

Has your condition worsened in the past 3-6 months:

_____

_____

_____

Have you:

Thought you had a thyroid problem, but not had a diagnosis: ☐ Y ☐ N

Been tested for an auto-immune condition: ☐ Y ☐ N

Been diagnosed with an auto-immune condition: ☐ Y ☐ N

4. What are the three things your condition has caused you to miss most:

_____

_____

_____

_____

5. Symptoms(list all):

_____

_____

_____

_____

_____

6. Severity of problem (check):

☐ **Minimal** (annoying but causing no limitation)

☐ **Slight** (tolerable but causing a little limitation)

☐ **Moderate** (sometimes tolerable but definitely causing limitation)

☐ **Severe** (causing significant limitation)

☐ **Extreme** (causing near constant limitation (>80% of the time))

7. What relieves your symptoms or causes them to return:

_____

_____

8. Describe the first time you remember having symptoms:

_____

_____

9. If your symptoms include pain:

What is the quality (sharp, dull, stabbing, color, etc.): _____

Does the pain radiate? ☐ Y ☐ N where: _____

_____

10. Do your symptoms occur at a specific time, place, or environment? ☐

When and for how long do symptoms last each episode:

_____

_____

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11. What types of treatment have you received:

Prescription/Drug therapy _____

Nutritional _____

Alternative/Holistic _____

12. List your health goals in order of Importance:

_____

_____

_____

Motivation to achieve these goals (from 1-10):

13. What are you hoping happens today as a result of your consultation:

_____

_____

14. How often are you aware of your main problem (check one):

☐ Occasionally (25% of the time) ☐ Frequently (75% of the time)

☐ Intermittently (50% of the time) ☐ Constantly (100% of the time)

15. If you cannot find a solution to your problem what do you think will happen?

_____

_____

_____

16. Due to your condition have you lost time from (describe how much time and what tasks have been limited)?

Work: ☐ Describe: _____

Family: ☐ Describe: _____

Leisure Activities ☐ Describe: _____

Blood Sugar (Diabetic's Only)

HIGHEST your blood sugar gets **WITHOUT** medication: _____

LOWEST your blood sugar gets **WITHOUT** medication: _____

HIGHEST your blood sugar gets **WITH** medication: _____

LOWEST your blood sugar gets **WITH** medication: _____

Medications (List all prescription, over-the-counter, **botanicals, homeopathic, and supplements**)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical and Social History

Surgeries/Hospitalizations **Date**

_____

_____

_____

_____

_____

Trauma **Date**

_____

_____

_____

_____

_____

Past/Recent Illness **Date**

_____

_____

Marital Status: ☐ S ☐ M ☐ W ☐ Sep ☐ D Spouse _____

Children / ages: _____

Family History *(mother, father, siblings, spouse, children)* **Date**

_____

_____

Do you use: **Alcohol**: ☐ Y ☐ N **Tobacco**: ☐ Y ☐ N **Caffeine**: ☐ Y ☐ N

_____ drinks/week _____ pack/day _____ cups/day

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Review of Systems: Past and Current

(Have you ever had the following (Enter "**P**" for past and "**C**" for current - leave blank if you do not or have not experienced)

CONSTITUTIONAL
____ Fatigue
____ Recent weight change
____ Fever

EYES
____ Blurred/double vision
____ Glasses/contacts
____ Eye disease or injury

EAR/NOSE/MOUTH/THROAT
____ Swollen glands in neck
____ Hearing loss or ringing
____ Earaches or drainage
____ Chronic sinus problems or rhinitis
____ Nose bleeds
____ Mouth sores / Bleeding gums
____ Bad breath / bad taste
____ Sore throat or voice change

CARDIOVASCULAR
____ High Blood Pressure
____ Shortness of breath walking/lying
____ Heart disease
____ Chest pain or angina pectoris
____ Palpitation
____ Mitral Valve Prolapse
____ Feet or ankle swelling
____ Shortness of breath
____ Spitting up blood
____ Low Blood Pressure

PSYCHIATRIC
____ Insomnia
____ Memory loss or confusion
____ Nervousness
____ Depression

GENITOURINARY
____ Frequent urination
____ Burning or painful urination
____ Blood in urine
____ Change in force or strain urinating
____ Kidney stones
____ Sexual difficulty
____ Male : testicle pain
____ Female: pain / irregular periods
____ Female: pregnant
____ Bladder Infections
____ Kidney Disease
____ Hemorrhoids

GASTROINTESTINAL
____ Abdominal pain
____ Nausea or Vomiting
____ Rectal bleeding/blood in stool
____ Painful bm / constipation
____ Ulcer
____ Change in bowel movement
____ Frequent diarrhea
____ Loss of appetite

RESPIRATORY
____ Chronic or frequent cough
____ Spitting up blood
____ Pneumonia / Bronchitis
____ Shortness of breath
____ Wheezing
____ Asthma

ENDOCRINE
____ Glandular or hormone problem
____ Excessive thirst or urination
____ Heat or cold intolerance
____ Skin becoming dryer
____ Change in hat or glove size
____ Diabetes
____ Thyroid Disease

MUSCUOSKELETAL
____ Back pain
____ Joint pain
____ Joint stiffness and swelling
____ Muscle pain or cramps
____ Muscle or joint weakness
____ Difficulty walking
____ Cold extremities

INTEGUMENTARY (skin, breast)
____ Change in skin color
____ Change in Hair or Nails
____ Varicose veins
____ Breast pain / discharge
____ Breast lump
____ Hives or Eczema
____ Rash or itching

NEUROLOG ICAL
____ Freq./ recurring headaches
____ Migraine headache
____ Convulsions or seizures
____ Numbness or tingling
____ Tremors
____ Paralysis
____ Head injury
____ Light headed or dizzy
____ Stroke

HEMATOLOGIC/LYMPHATIC/OTHER
____ Slow to heal after cuts
____ Easy bleeding or bruising
____ Anemia
____ Phlebitis
____ Past transfusion
____ Enlarged glands
____ Blood or Plasma Transfusions
____ Hepatitis
____ Cancer
____ Infectious Mono
____ AIDS or HIV+
____ Venereal
____ Chicken pox

ALLERGIES / OTHER (medications, food, or environmental) _____

_____

_____

_____

RECENT TESTS (lab work, x-rays, CT, MRI) _____

_____

_____

_____

_____

OTHER PROVIDERS

_____

_____

_____

_____

Reviewing Doctor: _____

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Consent to Care

I do hereby authorize the doctors of The Wellness Connection to administer such care that is necessary for my particular case. This care may include functional, nutritional, and lifestyle evaluation, testing, consulting, and care, including dietary supplements. I understand and am informed that products and services are not provided by medical physicians and do not include prescription of legend drugs, surgery, or other conventional allopathic medical treatments. I further understand that consultations, evaluations, supplementation, lifestyle consultation, testing, recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients pertain to the functional health/whole body concept.

Furthermore, I authorize and agree to allow the doctor of chiropractic, certified functional medicine practitioners or certified individuals with diplomates in clinical nutrition and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor, including those working at the clinic or office listed below or any other office or clinic, to work with my case.

I authorize the doctors of The Wellness Connection to discuss the nature and purpose of my care and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand I have been informed that the methods of nutritional evaluation or testing made available to me are not intended to diagnose disease from an allopathic model of medicine. Rather, they are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor progress in achieving goals. I further understand that any recommendations are supportive in nature allowing the body to return to improved health. Like all other health care, results are not guaranteed and there is no promise to cure. Accordingly, I understand that payment(s) for services are not conditional on my response to care. Prorated fees for unused, prepaid services, however, will be refunded if I wish to cancel. No refunds will be available for any products purchased.

I understand the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that may be recommended are generally considered safe, however, some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be toxic in large doses. I also understand that nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may interact with some legend drugs. Accordingly, I agree to consult with my prescribing physician about any legend drugs I am taking and the impact of supplements, vitamins, minerals, food grade herbs, and other nutrients on such drugs. I will inform my health practitioner if I experience gastrointestinal upset (nausea, gas, stomachache, vomiting), allergic reactions (hives, rashes, itching, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients. Some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be inappropriate during pregnancy, and I will notify the health practitioner if I am or become pregnant.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees previously incurred will be due and payable at that time. I understand that the alternatives to the recommendations include doing nothing and/or seeking additional allopathic medical care.

I permit The Wellness Connection and their business associates to contact me, and all other responsible parties on my account, on my cell phone or other mobile devices concerning any and all aspects of my account.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of my treatment for my present condition and for any future conditions (s) for which I seek treatment.

Signature_____ **Date** _____
(If under age 18) Parent's signature

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have the right to receive a copy of the practices **Notice of Privacy Practices.** I understand if I have questions or complaints in regards to my privacy rights that I may contact the Privacy Officer of The Wellness Connection. I further understand that the practice will offer me updates to the **Notice of Privacy Practices** should it be amended, modified, or changed in anyway."

Signature_____ **Date** _____
(If under age 18) Parent's signature

☐ Patient doesn't want a copy at this time, but available if requested

☐ Patient refused to sign.