Welcome to Mason Wellness Center

Important: Please Read

We are excited that you are with us today. Below is a brief outline of what you can expect during your visit. We are here to serve you, so if you have any questions or concerns, please ask any of us at Mason Wellness Center.

Paperwork

Please complete this simple admitting paperwork as thoroughly as possible so we can have an understanding of your current state of health and your health goals.

Consultation

You will meet Dr. Mason and discuss your health concerns and health goals. After reviewing the information on your history form and asking some additional questions, Dr. Mason will determine whether or not he may be able to assist you in your health concerns.

Examination

The following information may be gathered during the examination, depending on what Dr. Mason feels is necessary for your case:

- ✓ Comprehensive Chiropractic Evaluation
- ✓ Computerized Thermal Scan
- ✓ Computerized Surface Electromyography Scan
- ✓ Computerized Heart Rate Variability
- ✓ Functional Assessments and Bilateral Foot Scans
- ✓ Motion Study Analysis

Report of Findings

Upon gathering the information from the examination and x-rays if needed, we will schedule you a time for the Doctor's Report with Dr. Mason. This is the most important appointment, as Dr. Mason will take time to review your results and prepare an action plan tailored to YOUR goals and needs. This appointment will thoroughly explain the findings from the first visit as well as care recommendations.

Welcome to Mason Wellness Center

The purpose of this office is to help people get well and stay well.

Please take some time to complete all questions as thoroughly as possible so our team can assess how we can best help you.

PERSONAL INFORMATION

Full name:	**Date:**
Address:	
Home Telephone:	**Work Phone:**
Mobile Telephone:	**Email Address:**
Best Time/Place to Contact You:	
Date of Birth:	**Age:**
No. of Children: **Pregnant? Yes** ☐ **No** ☐ * If you are pregnant, please ask for our pregnancy paperwork	
Marital Status: M S W D O	**Spouse/Guardian Name:**
Occupation:	
Hobbies/Interests/Sports:	

Have you received chiropractic care before? If so, from whom and when?

_____

Were X-Rays taken? If so, when?

_____

Who may we thank for referring you?

_____

ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE

*Many people consult our practice for wellness. If you have no symptoms or complaints and are here for chiropractic wellness services, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity.	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of time pain is present.
1.					
2.					
3.					
4.					

Are these conditions interfering with any of the following:

☐ Work/financial capacity ☐ Sleep ☐ Daily routine ☐ Sports/exercise ☐ Relationship/family ☐ Hobbies/Interests ☐ Other

Please explain:_____

_____

What aggravates you problem/s?:

_____

What relieves your problem/s?

_____

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? [i.e. Eat better, less alcohol or drugs, meditate or breathe more, less contact sports, activities, etc]. If yes, what?

_____

Have you seen any other health care providers for this condition? ☐ No ☐ Yes. If yes, please provide details

_____

GENERAL HEALTH HISTORY

Often times, accumulation of life's three main stressors can lead to health problems and influence our ability to heal. Please pay close attention to this section, as it will help us help you!

First Main Stressor - Physical Stressors

Have you had any surgery? [Please include all surgery]

1. Type:	When?
2. Type:	When?
3. Type:	When?

Have you had any accidents and/or injuries during your lifetime?: e.g car, bike motorbike, work-related, or other [especially those related to your present problems]? Please include any broken bones/dislocations

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Please check the appropriate answer for each of the following questions:

	Daily/almost daily	**Yes, occasionally**	**Not at all**
Do you exercise?			
Do you play contact sports?			
Do you sit for long periods of time?			
Do you regularly bend and lift?			
Do you spend more than 2 hours per day using a computer?			

Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? Yes ☐ No ☐

Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? Yes ☐ No ☐

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

Poor – 1 2 3 4 5 6 7 8 9 10 - Excellent

Second Main Stressor - Bio-Chemical Stressors

Diet

Please check the dietary selection that is appropriate for you for each of the following:

	Daily	**Weekly**	**Monthly**	**Do not consume**
Alcohol				
Fruit				
Fish				
Dairy				
Eggs				
Coffee/Tea				
Soft/Energy Drinks				
Refined Sugars				
Skip Meals				
Red meat				
Fried Foods				
Vegetables				
Artificial Sweetener				
Organic Foods				
Fish/ Seafood				
Tobacco				
Diet Food				
Whole Grains				
Poultry				

Personal satisfaction with diet [please check]:

☐ Highly Satisfied	☐ Satisfied	☐ Unsatisfied	☐ Highly Unsatisfied

Current Medicines and Supplements

Please list any medications/drugs [prescription and non-prescription] you have taken in the past 6 months and why: (e.g. l·ŎŜűl·Y ʎyƻǈKŜy ύ¢èƭŜyƻƭύ, antibiotics.ύ____

____

Please list all nutritional supplements, vitamins, homeopathic remedies you currently take._______________________

Are you exposed to pollutants, strong smells or aerosols? ☐ Yes ☐ No ☐ Occasionally

Do you use natural/environmentally friendly products at home? i.e. cleaning products or personal care items? ☐ Yes ☐ No

Third Main Stressor - Mental/Emotional Stressors

Have any of the following occurred recently:

☐ Depression	☐ Divorce	☐ Drugs/Alcohol Increase	☐ Anxiety
☐ Death	☐ Change in Job Status	☐ Sleep Disturbances	☐ Family Problems
☐ Increased Work Stress	☐ Chronic Fatigue	☐ Economic Stress	☐ Other

Please comment if appropriate: ____

Do you regularly practice some form of meditation, breath work, other mind-body movement or have a routine/strategy to deal with stress? ☐ No ☐ Yes. Explain____

HEALTH HISTORY

Please mark in the boxes below if you have experienced any of the following;

Neck pain ☐ Currently ☐ In past	**Stiff Neck** ☐ Currently ☐ In past	**Headaches** ☐ Currently ☐ In past	**Shoulder Pain** ☐ Currently ☐ In past	**Pain in Mid-spine** ☐ Currently ☐ In past	**Low back pain** ☐ Currently ☐ In past
Allergies ☐ Currently ☐ In past	**Asthma** ☐ Currently ☐ In past	**Balance Loss** ☐ Currently ☐ In past	**Bloody nose** ☐ Currently ☐ In past	**Breathing problems** ☐ Currently ☐ In past	**Chest Pain** ☐ Currently ☐ In past
Constipation or Diarrhea ☐ Currently ☐ In past	**Cold/flu** ☐ Currently ☐ In past	**Cold Feet/Hands** ☐ Currently ☐ In past	**Depression** ☐ Currently ☐ In past	**Dizziness** ☐ Currently ☐ In past	**Ears Ring** ☐ Currently ☐ In past
Ear/throat Infections ☐ Currently ☐ In past	**Fainting** ☐ Currently ☐ In past	**Fatigue** ☐ Currently ☐ In past	**Fertility Challenges** ☐ Currently ☐ In past	**Loss of Memory** ☐ Currently ☐ In past	**Loss of Smell/Taste** ☐ Currently ☐ In past
Light Bothers Eyes ☐ Currently ☐ In past	**Loss of hearing** ☐ Currently ☐ In past	**Numbness in Fingers/Toes** ☐ Currently ☐ In past	**Nervousness** ☐ Currently ☐ In past	**Pins and Needles in Arms/ Legs** ☐ Currently ☐ In past	**Stomach/Digestive Problems** ☐ Currently ☐ In past
Shortness of Breath ☐ Currently ☐ In past	**Sleeping Problems** ☐ Currently ☐ In past	**Sinus problems** ☐ Currently ☐ In past	**Stop/Start Urination** ☐ Currently ☐ In past	**Tension & Irritability** ☐ Currently ☐ In past	**Weight Problems** ☐ Currently ☐ In past
Irregular Cycles ☐ Currently ☐ In past	**IVF program** ☐ Currently ☐ In past	**Lumps in breasts** ☐ Currently ☐ In past	**Menstrual Pain** ☐ Currently ☐ In past	**Menopausal Symptoms** ☐ Currently ☐ In past	**Other** ☐ Currently ☐ In past

Other [please explain]____

FAMILY HEALTH HISTORY

Please note any health issues that are present with family members such as parents, siblings & grandparents

☐ Cancer	☐ Diabetes	☐ Hypertension	☐ Heart Disease	☐ Arthritis	☐ Other

Comment (if relevant)____

HEALTH STATUS

Using the scale below, with 10 being excellent, please circle what you believe to be your current state of health.

0	1	2	3	4	5	6	7	8	9	10
Very Poor		Poor			Average		Good			Excellent

HEALTH GOALS

Which of these health goals are the most important to you? Please pick up to 5 and number them from 1 [most important] to 5 [least important]:

☐ **Energy Level and Fatigue** – Do you feel energetic or are you tired of being tired?
☐ **Quality of Sleep** – Do you have difficulty falling or staying asleep?
☐ **Memory and Ability to Focus**
☐ **Digestion** – Do you have problems with reflux, heartburn, bloating, etc.?
☐ **Nutrition** – How healthy is your diet?
☐ **Mood** – Are you happy, anxious, sad, or depressed?
☐ **Stress Levels** – How well are you handling the stresses in your life?
☐ **Allergies and Immune System** – Do you take allergy medication? Are you often sick?
☐ **Understanding more about health and how you and your family can stay healthy**.
☐ **Pain Control/Relief**
☐ **Health Reliability/Stability**- Ability to actively participate in all family/life activities that you need to/want to.

Are there any other health goals or conditions you'd like to work on?

_____

In what ways do you feel that your life is restricted?

_____

What is the best thing that will be added to your life when you regain your health?

_____

CONSENT TO CHIROPRACTIC CARE

Mason Wellness Center works to enhance your immune and nervous system through multiple modalities, including lifestyle changes and dietary instructions, as well as supplements, chiropractic and medical assessments which are all designed to attempt to enhance your immune and nervous system.

Chiropractic care is recognized as being an effective and safe method of care for many conditions. However, you must recognize that there are risks associated with all health care procedures, including assessment and treatment, which you should be informed about.

Please read the following carefully:

1. I acknowledge that I have discussed with the Dr. Mason the rare risks associated with my proposed care which include but are not limited to; muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.

2. I have had the opportunity to discuss the proposed care with the Dr. Mason. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.

3. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

4. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

5. In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (current statistics e.g. between 1 in 2 million to 1 in 5.85 million -Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (current statistics e.g. less than 1 in 139,000) and the low back (current statistics 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible."

…… …… …… ……

Patient's Signature | Patient's Name (printed) | Date: | Chiropractors signature