CONFIDENTIAL PATIENT INFORMATION

Personal Information **Date:**

Full name : First / Middle / Last	**Preferred Name (optional):** Preferred Pronouns(optional):
Address: Street / City / State / Zip	
Home phone (optional):	**Email:**
Cell phone:	
Preferred Contact: Call Home □ Call Cell □ Text □ Email □	**Preferred time for calls/texts:**
Date of birth:	**Age:**
Height:	**Pregnant? Yes □ No □ N/A □**
Weight:	**No. of children:**
Marital status:	**Spouse/guardian name:**
Occupation:	
Employer's name:	
Do you have a HSA or FLEX Card? Yes □ No □	

Check this box to give Body Wave permission to send SMS text messages

☐ YES, I would like to receive SMS text notifications from Body Wave (Text STOP to cancel at any time)

☐ NO, I would not like to receive SMS text notifications from Body Wave.

Date:_____ **Initials:**_____

How did you hear about our office? _____

Addressing What Brought You Into This Office:

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 the time pain is present
1.					
2.					
3.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

_____

Since the problem started is it: About the same? □ Getting better? □ Getting worse? □

What have you done for this condition? Was it of benefit?

_____

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 destructive sports, activities, etc.) If so, what?

_____

Is this condition interfering with: Work? _____ Sleep? _____ Daily routine? _____ Sports/ Exercise? _____ Other? _____

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

Past Health History
Please mark the following conditions you may have had or have now (- have had + have now):

Alcoholism	Allergy	Anemia	Arteriosclerosis	Arthritis	Asthma
Back Pain	Cancer	Cold Sores	Constipation	Convulsions	Depression
Diabetes	Diarrhea	Eczema	Emphysema	Epilepsy	Gall Bladder Problems
Gout	Headaches	Heart Attack	Heart Disease	High Blood Pressure	HIV (Aids)
Irregular Periods	Low Blood Sugar	Malaria	Measles	Menstrual Cramps	Migraines
Miscarriage	Multiple Sclerosis	Mumps	Neck Pain	Nervousness	Neuritis
Pleurisy	Pneumonia	Polio	Rheumatic Fever	Ringing in ears	Sinus Problems
Stroke	Thyroid Problems	Tuberculosis	Ulcers	Venereal Disease	Whooping Cough

Other (please explain) _____

Stressors
Because accumulation of stress affects our health and ability to heal please list the top stressors (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, broken bones, surgeries, etc.)
   a. _____
   b. _____
   c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

On a scale of 1-10 please grade your present levels of stress (10 being highly stressed):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent □	Good □	Fair □	Poor □	Getting better □	Getting worse □

How do you grade your emotional/mental health?

Excellent □	Good □	Fair □	Poor □	Getting better □	Getting worse □

Is there anything else which may help to better understand you which has not been discussed?

_____
_____
_____
_____
_____