



**Confidential New Patient Registration**

**Patient Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home# \_\_\_\_\_ Cell# \_\_\_\_\_  
 Email \_\_\_\_\_ Appointment reminders: email or text? Cell carrier \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M / F Marital Status S /M/ D/ W  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work# \_\_\_\_\_  
 Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse's/Partner's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Employer \_\_\_\_\_ Work# \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_  
 Type of Insurance:      Auto      Personal Injury      Private Ins      Workers' Comp      None  
 Primary Care Physician \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Reason for visit \_\_\_\_\_

**Private Health Insurance Information**

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Patient's Relationship to Insured      Self      Spouse/Partner      Child  
 Name of Insurance Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone# \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
**Secondary Insurance**      Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Name of Insurance Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone# \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Auto Injury / Personal Injury / Work Injury Information**

Insurance Type      Auto / Personal / Work Injury      Date of Injury \_\_\_\_\_  
 Patient's Relationship to Insured      Self / Partner/Spouse / Child  
 Describe how injury happened \_\_\_\_\_  
 \_\_\_\_\_  
 Name of Insurance Company \_\_\_\_\_ Phone# \_\_\_\_\_  
 Address \_\_\_\_\_  
 Adjuster Name \_\_\_\_\_ Phone# \_\_\_\_\_  
 Claim# \_\_\_\_\_ Policy# \_\_\_\_\_  
 Name of Attorney \_\_\_\_\_ Phone # \_\_\_\_\_  
 Were you working at the time of the accident (driving during work duty)?    Y / N  
 Dates lost from work as a result from this accident \_\_\_\_\_  
 If auto injury, were you the    Driver / Passenger / Pedestrian / Cyclist  
 Was your vehicle      Rear Ended / Hit from Side R / L / Head on  
 # of People in your vehicle \_\_\_\_\_ Were they injured?    Y / N



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## Office Policies

Element Wellness & Sports Rehabilitation welcomes you as a new patient. If you have any questions regarding our office policies, please ask any of our front desk staff for clarification prior to initialing.

### Please initial each of the following:

\_\_\_\_\_ **Cancellation Policy:** We require 24-hour notice for cancellations and rescheduling of appointments. If your appointment falls on a Monday or after a holiday, you must cancel the business day prior. **Cancellations must be made in person or by phone call, not through email.** If you fail to cancel 24 hours prior to the appointment, a charge of \$60 will be assessed to you. This charge is due before your next visit and cannot be billed to your insurance company. You will be personally responsible for the fee. Should you choose to take advantage of our package pricing on physical therapy, you will forfeit a full visit from your package. If three appointments are cancelled without 24-hour notice, your care is subject to termination.

\_\_\_\_\_ **Change of Insurance:** Please alert us right away if your insurance changes so that we can confirm your benefits.

\_\_\_\_\_ **Collection Policy:** We charge 3% monthly interest for all unpaid balances over 90 days. If an account is over six months in arrears, it will be subject to legal collection. The key to avoid this situation is communication. **WE WILL WORK WITH YOU!** Just talk to us. If an account is placed for collection a fee of 40% will be added to the account. In addition, you may be liable for attorney fees.

\_\_\_\_\_ **Motor Vehicle Accidents & Workplace Injuries:** Please notify us if you are in an accident. We will gladly bill your Personal Injury Protection or Workers' Compensation.

\_\_\_\_\_ **Insurance Maximums:** Should you need treatment beyond your insurance carrier's annual maximum coverage, we will gladly continue to work with you at our "pay at time of service rates".

\_\_\_\_\_ **Returned Check Policy:** Element Wellness & Sports Rehabilitation has a \$35 fee for all returned checks.

\_\_\_\_\_ **Please notify us** as soon as possible when your address and/or phone number changes.

\_\_\_\_\_ **Childcare Policy:** We do not offer childcare in this clinic. We do provide toys in the waiting area and you are welcome to bring your child/children in the treatment room as you see fit. Please do not leave children unattended.

\_\_\_\_\_ **Cell Phones:** For the comfort of our patients, we prohibit cell phone conversations in the clinic. **Please take all calls to the hallway and turn off all cell phones before entering the treatment rooms.**

\_\_\_\_\_ **HIPAA Notice of Privacy Practices:** We are required by law to maintain the privacy of, and provide individuals with, our HIPAA Notice of Privacy Practices. **By initialing, you acknowledge that you have been informed of and given the right to review and secure a copy of this notice.**

Please verify that you understand all of our office policies by signing and dating below.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient/Parent/Guardian/Legal Representative

\_\_\_\_\_  
Date



**Informed Consent to Chiropractic Treatment**

I, \_\_\_\_\_, hereby request and consent to the  
(Name of Patient) (Date of Birth)

performance of the chiropractic adjustment and other chiropractic procedures, including examination tests, and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by Dr. Noah Goodwill, D.C. and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for Dr. Noah Goodwill, D.C.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer’s syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. While these complications are very rare, soreness may be the only complication following a treatment. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the fact then known, and are in my best interest.

I have had an opportunity to discuss with Dr. Noah Goodwill, D.C., and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have, myself decided that is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment in this office.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

\_\_\_\_\_  
Signature of Patient/Parent/Guardian/Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Translated By

\_\_\_\_\_  
Date



**Consent to Use and Disclose Protected Health Information for  
Treatment, Payment or Healthcare Operation Form**

I \_\_\_\_\_ understand that as a part of my healthcare,  
(Name of Patient) (Date of Birth)

Element Wellness & Sports Rehabilitation originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment and history, public health and home health, as well as any plans for future care and treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnoses and referral information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the right to request restrictions as to how my health information may be used and disclosed to carry out treatment, payment and healthcare operations. Element Wellness & Sports Rehabilitation is not required to agree to the restrictions requested.

This consent remains in effect unless I give written notice to revoke. I understand that my refusal to give permission will not influence the services I received.

I wish to have the following restriction to the use and disclosure of my health information:

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\_\_\_\_\_  
Signature of Patient/Parent/Guardian/Legal Representative

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please describe how your symptoms **began**:

\_\_\_\_\_

\_\_\_\_\_

Do your symptoms **radiate** elsewhere?  No  Yes: \_\_\_\_\_

Did your symptoms begin **gradually** or **suddenly**? \_\_\_\_\_

Have your symptoms gotten **better/worse/remained the same**? \_\_\_\_\_

Are your symptoms **worse** in the:  AM  PM  Unchanged by time of day

What **type** of pain/discomfort do you have?

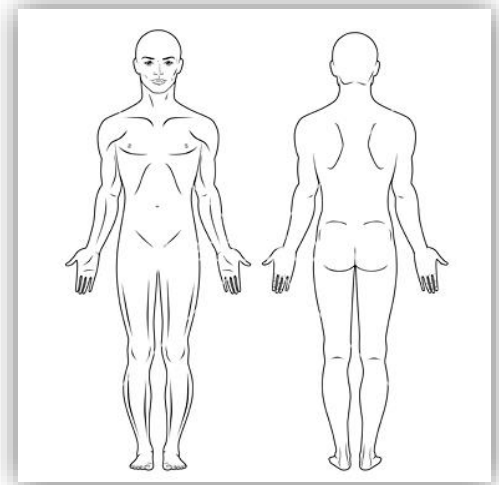
- pain  numbness  tingling  stiffness  
 soreness  swelling  weakness

How would you **describe** the pain/discomfort that you have?

- burning  dull  throbbing  superficial  "pins & needles"  
 shooting  stinging  tingling  deep  uncomfortable  
 aching  sharp  intense  numb

How **often** do you experience your symptoms?

- Occasionally (0-25%)  Intermittently (26-50%)  Frequently (51-75%)  Constantly (76-100%)



Indicate where you experience your symptoms.

Please list and rate the **location and intensity** of your **main area** of pain/discomfort at each state: \_\_\_\_\_

<b>WORST</b>	0	1	2	3	4	5	6	7	8	9	10
<b>CURRENT</b>	0	1	2	3	4	5	6	7	8	9	10
<b>BEST</b>	0	1	2	3	4	5	6	7	8	9	10
	-----Mild-----			-----Moderate-----				-----Severe-----			

Please list and rate the **location and intensity** of your **second area** of pain/discomfort at each state: \_\_\_\_\_

<b>WORST</b>	0	1	2	3	4	5	6	7	8	9	10
<b>CURRENT</b>	0	1	2	3	4	5	6	7	8	9	10
<b>BEST</b>	0	1	2	3	4	5	6	7	8	9	10
	-----Mild-----			-----Moderate-----				-----Severe-----			

Please list and rate the **location and intensity** of your **third area** of pain/discomfort at each state: \_\_\_\_\_

<b>WORST</b>	0	1	2	3	4	5	6	7	8	9	10
<b>CURRENT</b>	0	1	2	3	4	5	6	7	8	9	10
<b>BEST</b>	0	1	2	3	4	5	6	7	8	9	10
	-----Mild-----			-----Moderate-----				-----Severe-----			

How do your symptoms affect your **ability to perform daily activities**?

- No effect  Moderate effect (interferes)  Severe effect (no activity possible)  
 Mild effect (forgotten with activity)  Limiting effect (prevents full activity)

Which activities make your symptoms **worse**?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> No activities are painful      | <input type="checkbox"/> Lying on side        | <input type="checkbox"/> Pulling                     |
| <input type="checkbox"/> Inactivity                     | <input type="checkbox"/> Lying on back        | <input type="checkbox"/> Pushing                     |
| <input type="checkbox"/> Standing for more than 10 min. | <input type="checkbox"/> Sleeping             | <input type="checkbox"/> Squatting                   |
| <input type="checkbox"/> Standing for more than 60 min. | <input type="checkbox"/> Sexual activity      | <input type="checkbox"/> Lifting arms overhead       |
| <input type="checkbox"/> Walking short distances        | <input type="checkbox"/> Sitting              | <input type="checkbox"/> Turning over in bed         |
| <input type="checkbox"/> Getting in/out of car          | <input type="checkbox"/> Looking backwards    | <input type="checkbox"/> Changing directions quickly |
| <input type="checkbox"/> Bending forward                | <input type="checkbox"/> Going up/down stairs | <input type="checkbox"/> Running                     |
| <input type="checkbox"/> Putting on clothes             | <input type="checkbox"/> Work activities      | <input type="checkbox"/> Bicycling                   |
| <input type="checkbox"/> Putting on shoes               | <input type="checkbox"/> Reaching             | <input type="checkbox"/> Lifting heavy objects       |
| <input type="checkbox"/> Coughing/sneezing              | <input type="checkbox"/> Stooping             | <input type="checkbox"/> Lifting light objects       |
| <input type="checkbox"/> Home activities                | <input type="checkbox"/> Kneeling             | <input type="checkbox"/> Sports                      |
| <input type="checkbox"/> Standing up/sitting down       | <input type="checkbox"/> Balancing            | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Lying on stomach               | <input type="checkbox"/> Gripping             |  |

Which activities make your symptoms **better**?

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Ice             | <input type="checkbox"/> Brace/support/tape | <input type="checkbox"/> Lying on stomach  | <input type="checkbox"/> Acupuncture      |
| <input type="checkbox"/> Heat            | <input type="checkbox"/> Rest               | <input type="checkbox"/> Activity/movement | <input type="checkbox"/> Massage therapy  |
| <input type="checkbox"/> Muscle relaxer  | <input type="checkbox"/> Sleep              | <input type="checkbox"/> Exercise          | <input type="checkbox"/> Chiropractic     |
| <input type="checkbox"/> Pain medication | <input type="checkbox"/> Inactivity         | <input type="checkbox"/> Foam rolling      | <input type="checkbox"/> Physical therapy |
| <input type="checkbox"/> Hot shower/bath | <input type="checkbox"/> Lying on back      | <input type="checkbox"/> Stretching        | <input type="checkbox"/> Nothing          |

Have you experienced **these symptoms in the past**?  Yes  No

If yes, when did these symptoms last occur? What did you do to relieve your symptoms? Explain.

\_\_\_\_\_

How was the pain/discomfort **compared with this episode**?  Better  Worse  Remained the same

**Treatment History:**

Have you received medical attention for your **primary complaint**?  Yes  No

If yes, what is the name of the **provider** who treated you? When did you **first seek medical attention** for your primary complaint? \_\_\_\_\_

What **diagnoses/treatment** was given for your primary complaint?

How many times were you treated? Date of last treatment? \_\_\_\_\_

Did symptoms **get better/worse/remained the same** with past treatment? \_\_\_\_\_

Were **x-rays/CT scan/MRI images** taken?  Yes  No

If yes, what were the results? \_\_\_\_\_

**Review of Systems:**

Please check **all of the symptoms** that you are **CURRENTLY** experiencing. If none apply, check "None".

**CONSTITUTIONAL SYMPTOMS:**

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> General fatigue | <input type="checkbox"/> Unintentional weight loss    | <input type="checkbox"/> Dizziness    |
| <input type="checkbox"/> Fever           | <input type="checkbox"/> Loss of appetite             | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Malaise         | <input type="checkbox"/> Loss of sleep (due to pain)  | <input type="checkbox"/> Chills       |
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Loss of coordination/balance | <input type="checkbox"/> None         |

**EYES:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Blurred vision       | <input type="checkbox"/> Dry eyes                             | <input type="checkbox"/> Loss of vision       |
| <input type="checkbox"/> Pain behind the eyes | <input type="checkbox"/> Double vision                        | <input type="checkbox"/> Poor vision at night |
| <input type="checkbox"/> Crossed eyes         | <input type="checkbox"/> Nystagmus (involuntary eye movement) | <input type="checkbox"/> None                 |

**EARS/NOSE/THROAT:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Hay fever        | <input type="checkbox"/> Earache/infection |
| <input type="checkbox"/> Bleeding gums         | <input type="checkbox"/> Nosebleeds       | <input type="checkbox"/> Chronic sinusitis |
| <input type="checkbox"/> Ear discharge         | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> None              |
| <input type="checkbox"/> Loss of hearing       | <input type="checkbox"/> Ringing in ears  |  |
| <input type="checkbox"/> Hoarseness            | <input type="checkbox"/> Sinus problems   |  |

**RESPIRATORY:**

- |   |  |                               |
|---|--|-------------------------------|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> None |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Coughing up blood |                               |

**CARDIOVASCULAR:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Swollen ankles/feet |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Varicose veins      |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Poor circulation     | <input type="checkbox"/> None                |
| <input type="checkbox"/> Chest pains         | <input type="checkbox"/> Irregular heartbeat  |  |
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Rapid heartbeat      |  |

**GASTROINTESTINAL:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Bloating         | <input type="checkbox"/> Gas            | <input type="checkbox"/> Stomach pain   |
| <input type="checkbox"/> Constipation     | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Heartburn      |
| <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Hemorrhoids    | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Vomiting         | <input type="checkbox"/> Indigestion    | <input type="checkbox"/> Hepatitis      |
| <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Nausea         | <input type="checkbox"/> None           |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Ulcer          |   |

**GENTOURINARY:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Lack of bladder control | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Kidney stones        | <input type="checkbox"/> Blood in urine          | <input type="checkbox"/> Kidney disorder    |
| <input type="checkbox"/> Painful urination    | <input type="checkbox"/> Bladder infection       | <input type="checkbox"/> None               |

**MUSCULOSKELETAL:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Neck pain       | <input type="checkbox"/> Low back pain            | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Jaw pain        | <input type="checkbox"/> Wrist/hand pain          | <input type="checkbox"/> Muscle fatigue |
| <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Hip/upper leg pain       | <input type="checkbox"/> Muscle spasm   |
| <input type="checkbox"/> Arm/elbow pain  | <input type="checkbox"/> Knee/lower leg pain      | <input type="checkbox"/> None           |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Ankle/foot pain          |   |
| <input type="checkbox"/> Mid back pain   | <input type="checkbox"/> Joint swelling/stiffness |   |

**SKIN:**

- |   |                                  |  |
|---|----------------------------------|--|
| <input type="checkbox"/> Changes in mole(s) | <input type="checkbox"/> Itching | <input type="checkbox"/> Sores that don't heal |
| <input type="checkbox"/> Hives              | <input type="checkbox"/> Scars   | <input type="checkbox"/> Bruises               |
| <input type="checkbox"/> Rashes             | <input type="checkbox"/> Eczema  | <input type="checkbox"/> None                  |

**BLOOD/LYMPH:**

- Diabetes Type I
- Diabetes Type II
- HIV/AIDS
- Rheumatoid arthritis
- Autoimmune disease
- Cancer
- Tumor
- Systemic lupus
- None

**ALLERGIES:**

- Corn
- Dairy
- Dander
- Dust
- Eggs
- Gluten
- Pollen
- Wheat
- Penicillin
- Bee sting
- Nuts
- Grass
- Shellfish
- None
- Other: \_\_\_\_\_

**MALES ONLY:**

- Erection difficulty
- Lump in testicles
- Penis discharge
- Prostate problems
- Sore on penis
- Painful urination
- Breast lump
- None
- Other: \_\_\_\_\_

**FEMALES ONLY:**

- Breast lump
- Breast discharge
- Vaginal discharge
- Bleeding between periods
- Extreme menstrual pain
- Hormonal replacement
- Abnormal Pap smear
- Abnormal menses
- Menopause
- Contraception use
- Hot flashes
- Painful intercourse
- Pregnancy
- Urinary incontinence
- None
- Other: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Occupational History:**

What is your **current** job occupation? \_\_\_\_\_

How long have you worked at this job? \_\_\_\_\_

How many **weekly hours** do you currently work? \_\_\_\_\_

How would you describe your work activity level?

- Sedentary
- Light
- Moderate
- Heavy
- Very heavy

Have you missed work due to pain/discomfort?  Yes  No If yes, how long? \_\_\_\_\_

**Wellness History:**

What is your current weight? \_\_\_\_\_

What is your current height? \_\_\_\_\_

Do you have a primary care physician?  Yes  No

When was your **last** physical exam? \_\_\_\_\_

What kind of **exercise** do you participate in (check all that apply)?

- Walking
- Dancing
- Basketball
- Rock climbing
- Running
- Plyometrics
- Baseball
- TRX Suspension
- Aerobic classes
- Pilates
- Soccer
- Calisthenics
- Cross Fit
- Spinning classes
- Hockey
- Nautilus
- Bicycling
- Yoga
- Football
- None
- Free weights
- Rowing
- Tennis
- Other: \_\_\_\_\_
- Martial arts
- Swimming
- Golf
- 

How many times per week do you exercise? \_\_\_\_\_



Do you smoke?  Yes  No If yes, how many packs **per day**? \_\_\_\_\_

Do you consume alcohol?  Yes  No If yes, how many drinks **per week**? \_\_\_\_\_

How many hours of sleep do you currently get **per night** on average? \_\_\_\_\_

Do you consider your diet healthy?  Yes  No If no, why? \_\_\_\_\_

**Personal Health History:**

Please check **all the symptoms** that you have had **in the past**.

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> General arthritis       | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Liver/gall bladder disorder |
| <input type="checkbox"/> Jaw pain                 | <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Excessive thirst          | <input type="checkbox"/> Kidney disorders            |
| <input type="checkbox"/> Neck pain                | <input type="checkbox"/> Abdominal pain          | <input type="checkbox"/> Dermatitis/eczema/rash    | <input type="checkbox"/> Kidney stones               |
| <input type="checkbox"/> Upper back pain          | <input type="checkbox"/> Heart attack            | <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Loss of bladder control     |
| <input type="checkbox"/> Mid back pain            | <input type="checkbox"/> Angina                  | <input type="checkbox"/> Miscarriage               | <input type="checkbox"/> Frequent urination          |
| <input type="checkbox"/> Low back pain            | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Hysterectomy              | <input type="checkbox"/> Bladder infection           |
| <input type="checkbox"/> Low back stiffness       | <input type="checkbox"/> High cholesterol        | <input type="checkbox"/> Contraception use         | <input type="checkbox"/> Prostate problems           |
| <input type="checkbox"/> Shoulder pain            | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Hormonal replacement      | <input type="checkbox"/> Constipation                |
| <input type="checkbox"/> Arm/elbow pain           | <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> General fatigue           | <input type="checkbox"/> Painful urination           |
| <input type="checkbox"/> Wrist pain               | <input type="checkbox"/> Earache/infection       | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Smoking/tobacco use         |
| <input type="checkbox"/> Hand pain                | <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Loss of appetite          | <input type="checkbox"/> Cancer                      |
| <input type="checkbox"/> Hip/upper leg pain       | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Depression                | <input type="checkbox"/> HIV/AIDS                    |
| <input type="checkbox"/> Ankle/foot pain          | <input type="checkbox"/> Muscular incoordination | <input type="checkbox"/> Abnormal weight loss/gain | <input type="checkbox"/> Tumor                       |
| <input type="checkbox"/> Leg numbness/tingling    | <input type="checkbox"/> Visual disturbances     | <input type="checkbox"/> Drug/alcohol dependency   | <input type="checkbox"/> None                        |
| <input type="checkbox"/> Joint swelling/stiffness | <input type="checkbox"/> Chronic sinusitis       | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Other: _____                |

Please describe the **treatment you received** for the above conditions and if any of the conditions are unresolved:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all the **surgical procedures** you have had, including the dates they were performed and other times you have been hospitalized:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family Health History:**

Please indicate below which of the following conditions your family has a history of and/or an immediate family member has experienced:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Drug/alcohol dependency | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Lung disease            | <input type="checkbox"/> Blood disorder (e.g. anemia) | <input type="checkbox"/> Huntington's disease | <input type="checkbox"/> Osteoporosis       |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Heart disease                | <input type="checkbox"/> Thyroid problems     | <input type="checkbox"/> Prostate issues    |
| <input type="checkbox"/> Bone/joint disorder     | <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> None               |
| <input type="checkbox"/> Autoimmune disease      | <input type="checkbox"/> High cholesterol             | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Other: _____       |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Migraine headaches           | <input type="checkbox"/> Liver disease        | _____                                       |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Osteoarthritis               | <input type="checkbox"/> Psychiatric issues   | _____                                       |

**Medication/Vitamin Supplementation:**

Please list all prescription and over-the-counter medications and nutritional/herbal supplements you are currently taking:

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**Goals for Treatment:**

Please indicate what your personal goals for treatment are:

- Reduce pain/discomfort     Increase range of motion     Return to work/school     Return to specific sport  
 Other:

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