



5331 SW Macadam Ave, Ste 105, Portland, OR 97239
T {503} 445 7999 F {503} 445 7997
ElementWellnessPDX.com

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:

Signature of Patient/Parent/Guardian/Legal Representative

Date



Name: _____

Date: _____

Mechanism of Injury

Date of the work-related injury: _____

Time of injury: _____

Where did injury occur? _____

Please describe the **how the injury occurred** in your own words:

Please describe the **environmental conditions** which may have contributed to your present injury (e.g. poor lighting, slippery floor, limited space, etc.). Be sure to distinguish natural hazards from hazards created by other employees.

What was your **immediate response** after the work-related injury?

- | | | |
|---|---|--|
| <input type="checkbox"/> Disoriented/dazed | <input type="checkbox"/> Felt tightness/stiffness | <input type="checkbox"/> Shock |
| <input type="checkbox"/> Felt physical discomfort | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Was shaken up but could think clearly |
| <input type="checkbox"/> Felt immediate pain | <input type="checkbox"/> Frightened | <input type="checkbox"/> No adverse effects |

When was your **last date** of work? _____

What is your **current** work status?

- | | | | |
|------------------------------------|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Full-time | <input type="checkbox"/> Part-time | <input type="checkbox"/> Overtime | <input type="checkbox"/> Light/restricted duty |
|------------------------------------|------------------------------------|-----------------------------------|--|

Were there any witnesses to the injury? Yes No What date did you report this injury? _____

Whom did you report this injury to? _____

Medical Attention

Did you receive emergency medical attention (EMS) at the scene of the accident? Yes No

If yes, please describe: _____

Have you received medical attention **since the initial injury**? Yes No If yes, what date? _____

If yes, what doctor/hospital/clinic did you go to? _____

If yes, what **treatment/diagnosis** was given? _____

Was medication prescribed? Yes No If yes, please specify: _____

What percentage have your symptoms **improved from past treatment**? _____

How many times have you been seen **since the injury**? _____ Date of last treatment? _____

Were x-rays taken? Yes No If yes, which region(s) was x-rayed? _____

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

Please provide a detailed job description including what you do on a regular basis, how much weight you lift on average, how much walking/standing/sitting you do, and describe any repetitive movements, etc:

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

Do you have a **SECOND** job? Yes No

If yes, what is your **second** 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

Please provide a detailed job description including what you do on a regular basis, how much weight you lift on average, how much walking/standing/sitting you do, and describe any repetitive movements, etc:

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

Current Symptoms:

Check **ALL** the symptoms that have become apparent **SINCE THIS INJURY** (if no symptoms, check "None").

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle soreness/tightness |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Double vision | <input type="checkbox"/> Nausea | <input type="checkbox"/> Neck soreness/tightness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Upper back stiffness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Other visual disturbances | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Lower back stiffness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Constipation | <input type="checkbox"/> Upper extremity stiffness |
| <input type="checkbox"/> Feeling faint | <input type="checkbox"/> Pain behind the eyes | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Lower extremity stiffness |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Ringing/buzzing in ears | <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Right arm numbness/tingling |
| <input type="checkbox"/> Confusion/disorientation | <input type="checkbox"/> Sensitivity to sound | <input type="checkbox"/> Gluteal pain | <input type="checkbox"/> Left arm numbness/tingling |

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Genital pain | <input type="checkbox"/> Right leg numbness/tingling |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Left leg numbness/tingling |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Headaches | <input type="checkbox"/> Throat pain | <input type="checkbox"/> Pain between shoulder blades |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stress | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> None |
| <input type="checkbox"/> Muscular incoordination | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Muscle spasm | <input type="checkbox"/> Other: _____ |

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?

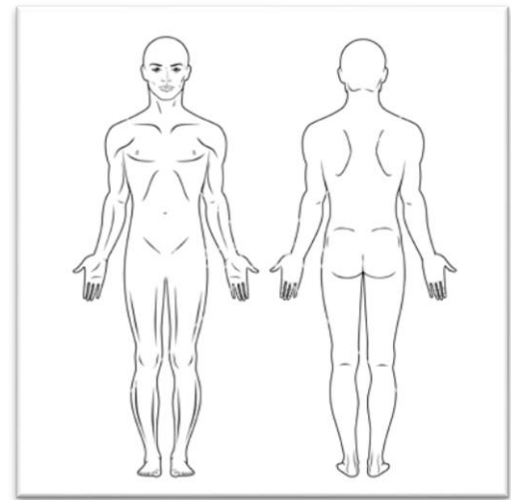
- | | | | |
|-----------------------------------|-----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> pain | <input type="checkbox"/> numbness | <input type="checkbox"/> tingling | <input type="checkbox"/> stiffness |
| <input type="checkbox"/> soreness | <input type="checkbox"/> swelling | <input type="checkbox"/> weakness | |

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

- | | | | | |
|-----------------------------------|-----------------------------------|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> burning | <input type="checkbox"/> dull | <input type="checkbox"/> throbbing | <input type="checkbox"/> superficial | <input type="checkbox"/> "pins & needles" |
| <input type="checkbox"/> shooting | <input type="checkbox"/> stinging | <input type="checkbox"/> tingling | <input type="checkbox"/> deep | <input type="checkbox"/> uncomfortable |
| <input type="checkbox"/> aching | <input type="checkbox"/> sharp | <input type="checkbox"/> intense | <input type="checkbox"/> numb | |

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Occasionally
(0-25%) | <input type="checkbox"/> Intermittently
(26-50%) | <input type="checkbox"/> Frequently
(51-75%) | <input type="checkbox"/> Constantly
(76-100%) |
|--|---|---|--|



Indicate where you experience your symptoms.

Please rate the **intensity** of your **main area** (Specify here: _____) of pain/discomfort at each state.

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

Please rate the **intensity** of your **second area** (Specify here: _____) of pain/discomfort at each state.

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

Please rate the **intensity** of your **third area** (Specify here: _____) of pain/discomfort at each state.

WORST	0	1	2	3	4	5	6	7	8	9	10	
CURRENT	0	1	2	3	4	5	6	7	8	9	10	
BEST	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**?

- | | | |
|--|---|---|
| <input type="checkbox"/> No effect | <input type="checkbox"/> Moderate effect (interferes) | <input type="checkbox"/> Severe effect (no activity possible) |
| <input type="checkbox"/> Mild effect (forgotten with activity) | <input type="checkbox"/> 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 |

Prior to the work-related injury, were you experiencing symptoms of any kind? Yes No

If yes, please describe:

What **percentage of improvement** did you experience with previous treatment? _____

In the **past**, have you ever experience the symptoms you are currently experiencing? Yes No

If yes, how did these previous symptoms occur?

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 | |

GENITOURINARY:

- | | | |
|---|--|---|
| <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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Systemic lupus |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> None |

ALLERGIES:

- | | | |
|---------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Corn | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Nuts | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Pollen/dust | <input type="checkbox"/> None |
| <input type="checkbox"/> Gluten/wheat | <input type="checkbox"/> Grass | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Dander | |

MALES ONLY:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Erection difficulty | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Lump in testicles | <input type="checkbox"/> Sore on penis | <input type="checkbox"/> None |
| <input type="checkbox"/> Penis discharge | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Other: _____ |

FEMALES ONLY:

- | | | |
|---|---|---|
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Hormonal replacement | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Breast discharge | <input type="checkbox"/> Abnormal Pap smear | <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Abnormal menses | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Menopause | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Extreme menstrual pain | <input type="checkbox"/> Contraception use | <input type="checkbox"/> None |

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? _____ Where the results normal/abnormal? _____

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? _____

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

- | | | | |
|--|---|-------------------------------------|---|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Dancing | <input type="checkbox"/> Basketball | <input type="checkbox"/> Rock climbing |
| <input type="checkbox"/> Running | <input type="checkbox"/> Plyometrics | <input type="checkbox"/> Baseball | <input type="checkbox"/> TRX Suspension |
| <input type="checkbox"/> Aerobic classes | <input type="checkbox"/> Pilates | <input type="checkbox"/> Soccer | <input type="checkbox"/> Calisthenics |
| <input type="checkbox"/> Cross Fit | <input type="checkbox"/> Spinning classes | <input type="checkbox"/> Hockey | <input type="checkbox"/> Nautilus |
| <input type="checkbox"/> Bicycling | <input type="checkbox"/> Yoga | <input type="checkbox"/> Football | <input type="checkbox"/> None |
| <input type="checkbox"/> Free weights | <input type="checkbox"/> Rowing | <input type="checkbox"/> Tennis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Martial arts | <input type="checkbox"/> Swimming | <input type="checkbox"/> Golf | _____ |

How many times per week do you exercise? _____

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 | |

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:

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