CARE NATURAL WELLNESS CENTER

1051 Eber Blvd., Suite 102, Melbourne, FL 32904
Ph: 321-728-1387 Fax: 321-728-1386

NEW PATIENT INFORMATION FORM

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. If something doesn't apply to you, please write 'NA'. **PLEASE PRINT USING BLUE OR BLACK INK.**

Today's Date_____

Name_____Home Phone _____ Work Phone _____

Address_____City _____State _____ Zip _____

Cell Phone _____ Email Address _____

Birthdate _____Sex: ___M ___ F Marital Status: ___S ___M ___W ___D

Employer _____ Occupation _____

Employer Address _____

Name of Spouse _____ Birthdate _____

Spouse's Employer _____ Occupation _____

Employer Address _____ Phone _____

Describe health of spouse: _____ Number of children if any _____

Whom may we thank for referring you:_____

Is this your first visit to a Chiropractic Office? ____Yes ____No

Is this condition due to an accident? ____Yes ____No ***(If yes, please ask receptionist for an accident data sheet.)***

Date of accident: _____ Type: ___Auto ___Work ___Home ___Other _____

Do you have Medicare Insurance? ____Yes ____No

IN CASE OF EMERGENCY, CONTACT: _____Relationship_____

Address:_____

Home Phone_____ Work Phone _____ Cell Phone _____

What is your major complaint (reason you are here): _____

_____

Previous treatments for this complaint:_____

_____

Other complaints or problems: _____

_____

Current medications/drugs being taken: _____

_____

_____

Current Nutritional Supplements:_____

_____

_____

Allergies to medicines, food, etc. _____

_____

CARE NATURAL WELLNESS CENTER

NEW PATIENT INFORMATION FORM-continued

Are you currently under the care of a physician or other health care professionals? (If yes, please give name and date of last visit): _____

_____

HISTORY:

List any surgery or operations with approx. dates: _____

_____

Have you been in an auto or other accident: ___past year ___past five years ___over five years ___ Never

Describe: _____

Have you ever had any mental or emotional disorders? ___Yes ___No When? _____

Have others in your family had such disorders? ___Yes ___No When? _____

Have you ever been knocked unconscious? ___Yes ___No Describe:_____

Have you ever had a fractured bone or dislocation? ___Yes ___No Describe: _____

Do you smoke, drink coffee, soda or alcohol? (If yes, indicate how much) Cigarettes _____ packs/day

Coffee_____cups/day Soda _____ cans or oz./day Alcohol _____ drinks/week

What is your current Stress Level? ___Low ___Medium ___High Reason:_____

How often do you exercise? ____ None ____ 1-2 times/week ____ 3-5 times/week ____ 6-7 times/week

How many bowel movements do you have? ____ per day/week (circle one)

Any household pets or other animals you or family members are in close contact with: _____

_____

What can we do to make you happier?_____

_____

I understand that all medical records are the property of CARE Natural Wellness Center and the original shall remain in their office as required by Florida law. Should I need copies of said records, an appropriate fee may be assessed for the cost of making such copies as provided by Board of Chiropractic Medicine Rule 64B2-17.0055.

I authorize CARE Natural Wellness Center to send me written correspondence, including their monthly health newsletter, by email when appropriate. I authorize my name to appear on the New Patient Referral Board if I refer a new patient to this office.

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____

(Rev 11/15/16)

CARE NATURAL WELLNESS CENTER
Confidential Patient Case History

Name _____ Date _____

Please check the appropriate box for any of the following symptoms, which you currently have or have had in the past. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

C-CURRENT
P-PAST

C	P	GENERAL
☐	☐	Allergy
☐	☐	Chills
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Headache
☐	☐	Loss of Sleep
☐	☐	Loss of weight
☐	☐	Nervousness/depression
☐	☐	Neuralgia
☐	☐	Numbness
☐	☐	Sweats
☐	☐	Tremors
		MUSCLE & JOINT
☐	☐	Arthritis
☐	☐	Bursitis
☐	☐	Carpal Tunnel Syndrome
☐	☐	Foot trouble
☐	☐	Hernia
☐	☐	Low back pain
☐	☐	Neck pain or stiffness
☐	☐	Pain between shoulders
		Pain or numbness in:
☐	☐	Shoulders
☐	☐	Arms
☐	☐	Elbows
☐	☐	Hands
☐	☐	Hips
☐	☐	Legs
☐	☐	Knees
☐	☐	Feet
☐	☐	Painful tail bone
☐	☐	Poor posture
☐	☐	Sciatica
☐	☐	Spinal Curvature
☐	☐	Swollen joints

C	P	GASTRO-INTESTINAL
☐	☐	Belching or gas
☐	☐	Colitis
☐	☐	Colon trouble
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Difficult digestion
☐	☐	Distension of abdomen
☐	☐	Excessive hunger
☐	☐	Gall bladder trouble
☐	☐	Hemorrhoids
☐	☐	Intestinal worms
☐	☐	Jaundice
☐	☐	Liver trouble
☐	☐	Nausea
☐	☐	Pain over stomach
☐	☐	Poor appetite
☐	☐	Vomiting
☐	☐	Vomiting of blood
		EYES, EARS, NOSE & THROAT
☐	☐	Asthma
☐	☐	Colds
☐	☐	Crossed eyes
☐	☐	Deafness
☐	☐	Dental decay
☐	☐	Earache
☐	☐	Ear discharge
☐	☐	Ear noises
☐	☐	Enlarged glands
☐	☐	Enlarged thyroid
☐	☐	Eye pain
☐	☐	Failing vision
☐	☐	Far sightedness
☐	☐	Gum trouble
☐	☐	Hay fever
☐	☐	Hoarseness
☐	☐	Nasal obstruction
☐	☐	Near sightedness
☐	☐	Nosebleeds
☐	☐	Sinus infection
☐	☐	Sore throat
☐	☐	Tonsillitis

C	P	CARDIO-VASCULAR
☐	☐	Hardening of arteries
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Pain over heart
☐	☐	Poor circulation
☐	☐	Rapid heart beat
☐	☐	Slow heart beat
☐	☐	Swelling of ankles
		RESPIRATORY
☐	☐	Chest pain
☐	☐	Chronic cough
☐	☐	Difficult breathing
☐	☐	Spitting up blood
☐	☐	Spitting up phlegm
☐	☐	Wheezing
		SKIN
☐	☐	Boils
☐	☐	Bruise easily
☐	☐	Dryness
☐	☐	Hives or allergy
☐	☐	Itching
☐	☐	Skin eruptions (rash)
☐	☐	Varicose veins
		GENITO-URINARY
☐	☐	Bed-wetting
☐	☐	Blood in urine
☐	☐	Frequent urination
☐	☐	Inability to control bladder
☐	☐	Kidney infection or stones
☐	☐	Painful urination
☐	☐	Prostate trouble
☐	☐	Pus in urine
		FOR WOMEN ONLY
☐	☐	Congested breasts
☐	☐	Cramps or backache
☐	☐	Excessive menstrual flow
☐	☐	Hot flashes
☐	☐	Irregular cycle
☐	☐	Menopausal symptoms
☐	☐	Painful menstruation
☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Chorea	☐ Fever Blisters	☐ Miscarriage	☐ Scarlet fever
☐ Anemia	☐ Cold Sores	☐ Goiter	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diabetes	☐ Gout	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Diphtheria	☐ Heart disease	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Eczema	☐ Influenza	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Emphysema	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Chicken Pox	☐ Epilepsy	☐ Measles	☐ Rheumatic Fever	☐ Whooping cough

(Rev 11/15/16)

SYMPTOM SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___

Sex: Male ☐ Female ☐

Vegetarian: Yes ☐ No ☐

INSTRUCTIONS: Fill in only the circles which apply to you.
1- ● ○ ○ MILD symptoms (occurred once or twice last 6 months).
2- ○ ● ○ MODERATE symptoms (occurred once or twice last month).
3- ○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
○ ○ ○ Leave circles BLANK if they don't apply to you!

	1 2 3	GROUP 1
1	○ ○ ○	Acid foods upset
2	○ ○ ○	Get chilled often
3	○ ○ ○	"Lump" in throat
4	○ ○ ○	Dry mouth-eyes-nose
5	○ ○ ○	Pulse speeds after meal
6	○ ○ ○	Keyed up - fail to calm
7	○ ○ ○	Cut heals slowly
8	○ ○ ○	Gag easily
9	○ ○ ○	Unable to relax; startles easily
10	○ ○ ○	Extremities cold, clammy
11	○ ○ ○	Strong light irritates
12	○ ○ ○	Urine amount reduced
13	○ ○ ○	Heart pounds after retiring
14	○ ○ ○	"Nervous" stomach
15	○ ○ ○	Appetite reduced
16	○ ○ ○	Cold sweats often
17	○ ○ ○	Fever easily raised
18	○ ○ ○	Neuralgia-like pains
19	○ ○ ○	Staring, blinks little
20	○ ○ ○	Sour stomach often
		GROUP 2
21	○ ○ ○	Joint stiffness on arising
22	○ ○ ○	Muscle-leg-toe cramps at night
23	○ ○ ○	"Butterfly" stomach, cramps
24	○ ○ ○	Eyes or nose watery
25	○ ○ ○	Eyes blink often
26	○ ○ ○	Eyelids swollen, puffy
27	○ ○ ○	Indigestion soon after meals
28	○ ○ ○	Always seems hungry; feels "lightheaded" often
29	○ ○ ○	Digestion rapid
30	○ ○ ○	Vomiting frequent
31	○ ○ ○	Hoarseness frequent
32	○ ○ ○	Breathing irregular
33	○ ○ ○	Pulse slow; feels "irregular"
34	○ ○ ○	Gagging reflex slow
35	○ ○ ○	Difficulty swallowing
36	○ ○ ○	Constipation, diarrhea alternating
37	○ ○ ○	"Slow starter"
38	○ ○ ○	Get "chilled" infrequently
39	○ ○ ○	Perspire easily
40	○ ○ ○	Circulation poor, sensitive to cold
41	○ ○ ○	Subject to colds, asthma, bronchitis
		GROUP 3
42	○ ○ ○	Eat when nervous
43	○ ○ ○	Excessive appetite
44	○ ○ ○	Hungry between meals
45	○ ○ ○	Irritable before meals
46	○ ○ ○	Get "shaky" if hungry
47	○ ○ ○	Fatigue, eating relieves
48	○ ○ ○	"Lightheaded" if meals delayed
49	○ ○ ○	Heart palpitates if meals missed or delayed
50	○ ○ ○	Afternoon headaches
51	○ ○ ○	Overeating sweets upsets
52	○ ○ ○	Awaken after few hours sleep - hard to get back to sleep
53	○ ○ ○	Crave candy or coffee in afternoons
54	○ ○ ○	Moods of depression - "blues" or melancholy
55	○ ○ ○	Abnormal craving for sweets or snacks
		GROUP 4
56	○ ○ ○	Hands and feet go to sleep easily, numbness
57	○ ○ ○	Sigh frequently, "air hunger"
58	○ ○ ○	Aware of "breathing heavily"
59	○ ○ ○	High altitude discomfort
60	○ ○ ○	Opens windows in closed rooms
61	○ ○ ○	Susceptible to colds and fevers
62	○ ○ ○	Afternoon "yawner"
63	○ ○ ○	Get "drowsy" often
64	○ ○ ○	Swollen ankles, worse at night
65	○ ○ ○	Muscle cramps, worse during exercise; get "charley horses"
66	○ ○ ○	Shortness of breath on exertion
67	○ ○ ○	Dull pain in chest or radiating into left arm, worse on exertion
68	○ ○ ○	Bruise easily, "black and blue" spots
69	○ ○ ○	Tendency to anemia
70	○ ○ ○	"Nose bleeds" frequent
71	○ ○ ○	Noises in head, or "ringing in ears"
72	○ ○ ○	Tension under the breastbone, or feeling of "tightness", worse on exertion
		GROUP 5
73	○ ○ ○	Dizziness
74	○ ○ ○	Dry skin
75	○ ○ ○	Burning feet
76	○ ○ ○	Blurred vision
77	○ ○ ○	Itching skin and feet
78	○ ○ ○	Excessive falling hair
79	○ ○ ○	Frequent skin rashes
80	○ ○ ○	Bitter, metallic taste in mouth in mornings
81	○ ○ ○	Bowel movements painful or difficult
82	○ ○ ○	Worrier, feels insecure
83	○ ○ ○	Feeling queasy; headache over eyes
84	○ ○ ○	Greasy foods upset
85	○ ○ ○	Stools light colored
86	○ ○ ○	Skin peels on foot soles
87	○ ○ ○	Pain between shoulder blades
88	○ ○ ○	Use laxatives
89	○ ○ ○	Stools alternate from soft to watery
90	○ ○ ○	History of gallbladder attacks or gallstones
91	○ ○ ○	Sneezing attacks
92	○ ○ ○	Dreaming, nightmare type bad dreams
93	○ ○ ○	Bad breath (halitosis)
94	○ ○ ○	Milk products cause distress
95	○ ○ ○	Sensitive to hot weather
96	○ ○ ○	Burning or itching anus
97	○ ○ ○	Crave sweets
		GROUP 6
98	○ ○ ○	Loss of taste for meat
99	○ ○ ○	Lower bowel gas several hours after eating
100	○ ○ ○	Burning stomach sensations, eating relieves
101	○ ○ ○	Coated tongue
102	○ ○ ○	Pass large amounts of foul-smelling gas
103	○ ○ ○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○ ○ ○	Mucous colitis or "irritable bowel"
105	○ ○ ○	Gas shortly after eating
106	○ ○ ○	Stomach "bloating" after eating

	1	2	3	
				GROUP 7A
107	O	O	O	Insomnia
108	O	O	O	Nervousness
109	O	O	O	Can't gain weight
110	O	O	O	Intolerance to heat
111	O	O	O	Highly emotional
112	O	O	O	Flush easily
113	O	O	O	Night sweats
114	O	O	O	Thin, moist skin
115	O	O	O	Inward trembling
116	O	O	O	Heart palpitates
117	O	O	O	Increased appetite without weight gain
118	O	O	O	Pulse fast at rest
119	O	O	O	Eyelids and face twitch
120	O	O	O	Irritable and restless
121	O	O	O	Can't work under pressure
				GROUP 7B
122	O	O	O	Increase in weight
123	O	O	O	Decrease in appetite
124	O	O	O	Fatigue easily
125	O	O	O	Ringing in ears
126	O	O	O	Sleepy during day
127	O	O	O	Sensitive to cold
128	O	O	O	Dry or scaly skin
129	O	O	O	Constipation
130	O	O	O	Mental sluggishness
131	O	O	O	Hair coarse, falls out
132	O	O	O	Headaches upon arising, wear off during day
133	O	O	O	Slow pulse, below 65
134	O	O	O	Frequency of urination
135	O	O	O	Impaired hearing
136	O	O	O	Reduced initiative
				GROUP 7C
137	O	O	O	Failing memory
138	O	O	O	Low blood pressure
139	O	O	O	Increased sex drive
140	O	O	O	Headaches, "splitting or rending" type
141	O	O	O	Decreased sugar tolerance
				GROUP 7D
142	O	O	O	Abnormal thirst
143	O	O	O	Bloating of abdomen
144	O	O	O	Weight gain around hips or waist
145	O	O	O	Sex drive reduced or lacking
146	O	O	O	Tendency to ulcers, colitis
147	O	O	O	Increased sugar tolerance
148	O	O	O	Women: menstrual disorders
149	O	O	O	Young girls: lack of menstrual function
				GROUP 7E
150	O	O	O	Dizziness
151	O	O	O	Headaches
152	O	O	O	Hot flashes
153	O	O	O	Increased blood pressure
154	O	O	O	Hair growth on face or body (female)
155	O	O	O	Sugar in urine (not diabetes)
156	O	O	O	Masculine tendencies (female)
				GROUP 7F
157	O	O	O	Weakness, dizziness
158	O	O	O	Chronic fatigue
159	O	O	O	Low blood pressure
160	O	O	O	Nails weak, ridged
161	O	O	O	Tendency to hives
162	O	O	O	Arthritic tendencies
163	O	O	O	Perspiration increase
164	O	O	O	Bowel disorders
165	O	O	O	Poor circulation
166	O	O	O	Swollen ankles
167	O	O	O	Crave salt
168	O	O	O	Brown spots or bronzing of skin
169	O	O	O	Allergies - tendency to asthma

	1	2	3	
170	O	O	O	Weakness after colds, influenza
171	O	O	O	Exhaustion - muscular and nervous
172	O	O	O	Respiratory disorders
				GROUP 8
173	O	O	O	Apprehension
174	O	O	O	Irritability
175	O	O	O	Morbid fears
176	O	O	O	Never seems to get well
177	O	O	O	Forgetfulness
178	O	O	O	Indigestion
179	O	O	O	Poor appetite
180	O	O	O	Craving for sweets
181	O	O	O	Muscular soreness
182	O	O	O	Depression; feelings of dread
183	O	O	O	Noise sensitivity
184	O	O	O	Acoustic hallucinations
185	O	O	O	Tendency to cry without reason
186	O	O	O	Hair is coarse and/or thinning
187	O	O	O	Weakness
188	O	O	O	Fatigue
189	O	O	O	Skin sensitive to touch
190	O	O	O	Tendency toward hives
191	O	O	O	Nervousness
192	O	O	O	Headache
193	O	O	O	Insomnia
194	O	O	O	Anxiety
195	O	O	O	Anorexia
196	O	O	O	Inability to concentrate; confusion
197	O	O	O	Frequent stuffy nose; sinus infections
198	O	O	O	Allergy to some foods
199	O	O	O	Loose joints
				FEMALE ONLY
200	O	O	O	Very easily fatigued
201	O	O	O	Premenstrual tension
202	O	O	O	Painful menses
203	O	O	O	Depressed feelings before menstruation
204	O	O	O	Menstruation excessive and prolonged
205	O	O	O	Painful breasts
206	O	O	O	Menstruate too frequently
207	O	O	O	Vaginal discharge
208		O		Hysterectomy / ovaries removed
209	O	O	O	Menopausal hot flashes
210	O	O	O	Menses scanty or missed
211	O	O	O	Acne, worse at menses
212	O	O	O	Depression of long standing
				MALE ONLY
213	O	O	O	Prostate trouble
214	O	O	O	Urination difficult or dribbling
215	O	O	O	Night urination frequent
216	O	O	O	Depression
217	O	O	O	Pain on inside of legs or heels
218	O	O	O	Feeling of incomplete bowel evacuation
219	O	O	O	Lack of energy
220	O	O	O	Migrating aches and pains
221	O	O	O	Tire too easily
222	O	O	O	Avoids activity
223	O	O	O	Leg nervousness at night
224	O	O	O	Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

CARE NATURAL WELLNESS CENTER

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Ph: 321-728-1387 Fax: 321-728-1386

Name_____ **Date** _____

DIETARY INTAKE FORM

Please record your dietary intake for the 2 days prior to your appointment.
(Record everything you eat and drink, including snacks/gum, and be specific.)

Day 1:
Breakfast:

Lunch:

Dinner:

Day 2:
Breakfast:

Lunch:

Dinner: