

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 _____
Apt # _____ 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 **Do you have Medicare Insurance?** ___ Yes ___ No
Is this condition due to an accident? ___ Yes ___ No
Date of accident: _____ Type: ___ Auto ___ Work ___ Home ___ Other _____
If you were in an auto accident, did you see a doctor within **14 days** of the accident? ___ 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, notices of classes, specials, hours changes, and other health information 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 5/1/20)

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

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

- | | | |
|--------------------------|--------------------------|--|
| C | P | CARDIO-VASCULAR |
| <input type="checkbox"/> | <input type="checkbox"/> | Hardening of arteries |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain over heart |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Slow heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of ankles |
| RESPIRATORY | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Spitting up blood |
| <input type="checkbox"/> | <input type="checkbox"/> | Spitting up phlegm |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing |
| SKIN | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Boils |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Dryness |
| <input type="checkbox"/> | <input type="checkbox"/> | Hives or allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | Itching |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin eruptions (rash) |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins |
| GENITO-URINARY | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bed-wetting |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Inability to control bladder |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney infection or stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Pus in urine |
| FOR WOMEN ONLY | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Congested breasts |
| <input type="checkbox"/> | <input type="checkbox"/> | Cramps or backache |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular cycle |
| <input type="checkbox"/> | <input type="checkbox"/> | Menopausal symptoms |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful menstruation |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> Are you pregnant? |

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- | | | | | |
|---|-------------------------------------|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chorea | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping cough |

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

1 2 3

- 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 Insomnia
 - 108 Nervousness
 - 109 Can't gain weight
 - 110 Intolerance to heat
 - 111 Highly emotional
 - 112 Flush easily
 - 113 Night sweats
 - 114 Thin, moist skin
 - 115 Inward trembling
 - 116 Heart palpitates
 - 117 Increased appetite without weight gain
 - 118 Pulse fast at rest
 - 119 Eyelids and face twitch
 - 120 Irritable and restless
 - 121 Can't work under pressure

GROUP 7B

- 122 Increase in weight
- 123 Decrease in appetite
- 124 Fatigue easily
- 125 Ringing in ears
- 126 Sleepy during day
- 127 Sensitive to cold
- 128 Dry or scaly skin
- 129 Constipation
- 130 Mental sluggishness
- 131 Hair coarse, falls out
- 132 Headaches upon arising, wear off during day
- 133 Slow pulse, below 65
- 134 Frequency of urination
- 135 Impaired hearing
- 136 Reduced initiative

GROUP 7C

- 137 Failing memory
- 138 Low blood pressure
- 139 Increased sex drive
- 140 Headaches, "splitting or rending" type
- 141 Decreased sugar tolerance

GROUP 7D

- 142 Abnormal thirst
- 143 Bloating of abdomen
- 144 Weight gain around hips or waist
- 145 Sex drive reduced or lacking
- 146 Tendency to ulcers, colitis
- 147 Increased sugar tolerance
- 148 Women: menstrual disorders
- 149 Young girls: lack of menstrual function

GROUP 7E

- 150 Dizziness
- 151 Headaches
- 152 Hot flashes
- 153 Increased blood pressure
- 154 Hair growth on face or body (female)
- 155 Sugar in urine (not diabetes)
- 156 Masculine tendencies (female)

GROUP 7F

- 157 Weakness, dizziness
- 158 Chronic fatigue
- 159 Low blood pressure
- 160 Nails weak, ridged
- 161 Tendency to hives
- 162 Arthritic tendencies
- 163 Perspiration increase
- 164 Bowel disorders
- 165 Poor circulation
- 166 Swollen ankles
- 167 Crave salt
- 168 Brown spots or bronzing of skin
- 169 Allergies - tendency to asthma

- 1 2 3**
- 170 Weakness after colds, influenza
 - 171 Exhaustion - muscular and nervous
 - 172 Respiratory disorders

GROUP 8

- 173 Apprehension
- 174 Irritability
- 175 Morbid fears
- 176 Never seems to get well
- 177 Forgetfulness
- 178 Indigestion
- 179 Poor appetite
- 180 Craving for sweets
- 181 Muscular soreness
- 182 Depression; feelings of dread
- 183 Noise sensitivity
- 184 Acoustic hallucinations
- 185 Tendency to cry without reason
- 186 Hair is coarse and/or thinning
- 187 Weakness
- 188 Fatigue
- 189 Skin sensitive to touch
- 190 Tendency toward hives
- 191 Nervousness
- 192 Headache
- 193 Insomnia
- 194 Anxiety
- 195 Anorexia
- 196 Inability to concentrate; confusion
- 197 Frequent stuffy nose; sinus infections
- 198 Allergy to some foods
- 199 Loose joints

FEMALE ONLY

- 200 Very easily fatigued
- 201 Premenstrual tension
- 202 Painful menses
- 203 Depressed feelings before menstruation
- 204 Menstruation excessive and prolonged
- 205 Painful breasts
- 206 Menstruate too frequently
- 207 Vaginal discharge
- 208 Hysterectomy / ovaries removed
- 209 Menopausal hot flashes
- 210 Menses scanty or missed
- 211 Acne, worse at menses
- 212 Depression of long standing

MALE ONLY

- 213 Prostate trouble
- 214 Urination difficult or dribbling
- 215 Night urination frequent
- 216 Depression
- 217 Pain on inside of legs or heels
- 218 Feeling of incomplete bowel evacuation
- 219 Lack of energy
- 220 Migrating aches and pains
- 221 Tire too easily
- 222 Avoids activity
- 223 Leg nervousness at night
- 224 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

1051 Eber Blvd., Suite 102, Melbourne, FL 32904

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: