# 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

**Patient Name** ______________________________.

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: ______________________

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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)

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Get Healthy.
Stay Healthy.
*Naturally.*

# Quality of Life Survey

**Name:** ______________________________ **Date:** __________________

Please take several minutes to answer these questions so we can help you get better.
**(Please check all that apply)**

## 01 How have you taken care of your health in the past?

- ☐ Medications
- ☐ Nutrition/Diet
- ☐ Emergency Room
- ☐ Holistic Care
- ☐ Routine Medical
- ☐ Vitamins
- ☐ Exercise
- ☐ Chiropractic
- ☐ Other (please specify): ______________________________

## 02 How did the previous method(s) work out for you?

- ☐ Bad Results
- ☐ Did Not Get Worse
- ☐ Some Results
- ☐ Did Not Work Very Long
- ☐ Great Results
- ☐ Still Trying
- ☐ Nothing Changed
- ☐ Confused

## 03 How have others been affected by your health condition?

- ☐ No One Is Affected
- ☐ They Tell Me To Do Something
- ☐ Haven’t Noticed Any Problem
- ☐ People Avoid Me

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**Patient Name** ______________________________.

**04** **What are you afraid this might be (or beginning) to affect (or will affect)?**

- ☐ Job
- ☐ Kids
- ☐ Future Ability
- ☐ Marriage
- ☐ Self-Esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

**05** **Are there health conditions you are afraid this might turn into?**

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need Surgery

**06** **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

**07** **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:**

**1.** ______________________________________________________

**2.** ______________________________________________________

**3.** ______________________________________________________

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**Patient Name** ______________________________.

**08** **What are you most concerned with regarding your problem?**

______________________________

______________________________

______________________________

______________________________

**09** **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

______________________________

______________________________

______________________________

______________________________

**10** **What would be different/better without this problem? Please be specific.**

______________________________

______________________________

**11** **What do you desire most to get from working with us?**

______________________________

______________________________

**12** **What would that mean to you?**

______________________________

______________________________

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**Patient Name** ______________________________.

# WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

**Let's get started**

Please check any that apply to you:

**Sub-Clinical Symptoms Including:**
- ☐ Headaches
- ☐ Migraines

**Hormone Imbalance Including:**
- ☐ PMS
- ☐ Emotional imbalance

**Gastrointestinal Issues Including:**
- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

**Respiratory Conditions Including:**
- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

**Joint Conditions Including:**
- ☐ Knee, Shoulder, or Spine

**Autoimmune Conditions Including:**
- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

**Thyroid Conditions Including:**
- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

**Developmental and Social Concerns Including:**
- ☐ Autism
- ☐ ADD/ADHD

**Skin Conditions Including:**
- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

| | None | Mild | Mod | Severe |
|---|---|---|---|---|
| Constipation and/or diarrhea | 0 | 1 | 2 | 3 |
| Abdominal pain or bloating | 0 | 1 | 2 | 3 |
| Mucous or blood in stool | 0 | 1 | 2 | 3 |
| Joint pain or swelling, arthritis | 0 | 1 | 2 | 3 |
| Chronic or frequent fatigue or tiredness | 0 | 1 | 2 | 3 |
| Food allergies, sensitivities or intolerance | 0 | 1 | 2 | 3 |
| Sinus or nasal congestion | 0 | 1 | 2 | 3 |
| Chronic or frequent inflammations | 0 | 1 | 2 | 3 |
| Eczema, skin rashes or hives (urticaria) | 0 | 1 | 2 | 3 |

| | None | Mild | Mod | Severe |
|---|---|---|---|---|
| Asthma, Hayfever, or airborne allergies | 0 | 1 | 2 | 3 |
| Confusion, poor memory or mood swings | 0 | 1 | 2 | 3 |
| Use of NSAIDS (Aspirin, Tylenol, Motrin) | 0 | 1 | 2 | 3 |
| History of antibiotic use | 0 | 1 | 2 | 3 |
| Alcohol consumption makes you feel sick | 0 | 1 | 2 | 3 |
| Gluten sensitivity or Celiac's disease | 0 | 1 | 2 | 3 |
| Nausea | 0 | 1 | 2 | 3 |
| Weight issues | 0 | 1 | 2 | 3 |

**YOUR TOTAL** ____________