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. _____

_____

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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)

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 5/2/05)