

CARE NATURAL WELLNESS CENTER
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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)

Quality of Life Survey

Company Information: _____

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?

- | | |
|--|---|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Nutrition/Diet |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Holistic Care |
| <input type="checkbox"/> Routine Medical | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Other (please specify): _____ | |

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

- | | |
|--|---|
| <input type="checkbox"/> Bad Results | <input type="checkbox"/> Did Not Get Worse |
| <input type="checkbox"/> Some Results | <input type="checkbox"/> Did Not Work Very Long |
| <input type="checkbox"/> Great Results | <input type="checkbox"/> Still Trying |
| <input type="checkbox"/> Nothing Changed | <input type="checkbox"/> Confused |

03 How have others been affected by your health condition?

- | | |
|--|---|
| <input type="checkbox"/> No One Is Affected | <input type="checkbox"/> They Tell Me To Do Something |
| <input type="checkbox"/> Haven't Noticed Any Problem | <input type="checkbox"/> People Avoid Me |

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

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Job | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Kids | <input type="checkbox"/> Time |
| <input type="checkbox"/> Future Ability | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Freedom |
| <input type="checkbox"/> Self-Esteem | |

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

- | | |
|---|--|
| <input type="checkbox"/> Family Health Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Need Surgery |
| <input type="checkbox"/> Arthritis | |

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.

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?

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 _____