

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 _____

Whom may we thank for referring you: _____

IN CASE OF EMERGENCY, CONTACT: _____ Relationship _____ Address: _____ Home Phone _____ Work Phone _____ Cell Phone _____

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

List any surgery or operations with approx. dates: _____

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)

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 _____

Metabolic Health Form

MEDICAL HISTORY

01 Do you or any family member have/had any of the following? Please put an "X" for you, and "F" for family

- | | | |
|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Brain Fog | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Poor Sleep |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Intestine Problems | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Knee Pain | | |

02 Is there a certain time of day any of these problems are better or worse?

03 Main Concerns:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

04 How long have you had this/these concerns?

05 What effect does this have on your body functions or quality of life?

06 What would be different or better without this/these concerns?

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Diminished Stress | <input type="checkbox"/> Family | <input type="checkbox"/> Confidence |
| <input type="checkbox"/> Work | <input type="checkbox"/> Improved Self-Esteem | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> More Energy | <input type="checkbox"/> Outlook | |

07 Are you taking any medications/supplements? If yes, please list.

08 Are you pregnant? _____ How many children? _____ How many Pregnancies? _____
Are you breast feeding? _____

09 Any known allergies? If yes, please list.

10 How have you addressed weight management in the past?

- Medications Vitamins Exercise Diet and Nutrition Other: _____

11 How did the previous methods work for you?

12 What potential barriers do you foresee that would prevent the change you are looking for?

13 Do you feel it possible to eliminate or prevent these potential barriers?

14 What outcome would you like to see for this to be a success for you?

15 Please rate on a scale of 1-10 (1 being the lowest and 10 being the highest)

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How Important It Is For You To Resolve Your Health Concerns	1	2	3	4	5	6	7	8	9	10
What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?	1	2	3	4	5	6	7	8	9	10

I AM INTERESTED IN:

- Weight Loss
- Anti-Aging
- Long-Term Results
- Inch Loss
- Metabolism Support

PERMISSION AND AUTHORIZATION

Dietary guidelines, nutritional supplements, red light therapy and whole body vibration are used at CARE Natural Wellness Center (CNWC) to enhance weight management and overall metabolic health. It is not a substitute for medical treatment and is not be used to diagnose or treat any medical condition. Consult your Medical Provider (including doctor/ physician, nurse, physician’s assistant, or any other health professional) before using any of the above therapies, especially if you have any pre-existing health concerns. Individual results may vary, and no guarantees are made regarding the effectiveness of treatment.

You are acknowledging that you are participating voluntarily in using our services and information, and you alone are solely and personally responsible for your choices, actions and results. I also understand that my health insurance will not be billed for the natural therapies offered at CNWC.

I have read and understand the foregoing and this permission form applies to subsequent visits and consultations.

Patient’s Signature _____ Date _____

Or Guardian Signature _____ Date _____

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 _____