Global Wellness
Chiropractic Clinic

WELCOME TO OUR OFFICE

PATIENT INFORMATION Today's Date ____/ ____ / ____

Legal Name _______________________________________Birthdate ____/ ____ / ____ Age ________
Preferred Name (if different than legal name)____
Address ____ City ______________State _______ Zip _________
Cell phone ___________________________________
Home phone __________________________________
Work phone___________________________________
E-mail Address ____
Employed by____ Occupation____________________________________

What is the best way to contact you?
□Cell phone □Home phone □Work phone □E-mail

Emergency Contact____ Emergency phone_________________________
Relationship to patient______________________________________

How did you hear about us? ____

Is this visit the result of an accident? (circle one) YES NO
Type of accident (circle one): AUTO ACCIDENT WORK ACCIDENT OTHER ACCIDENT
Date Injury Occurred ___________________________ Symptoms Started __________________________________

Are you on Medicare? (circle one) YES NO

I have read and understand the financial policy of Global Wellness Clinic, P.C. (GWCPC) I understand that my insurance is an arrangement between myself and my insurance company, NOT between GWCPC and my insurance company.

- ❖ I understand the Clinic's financial policy and realize that I am financially responsible for all services rendered, including those not covered by my insurance.
- ❖ I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.

I have read and agree to the above statement.

Printed name____

Signature ____Date ____________________
(Signature of parent/guardian if patient is a minor)

Initial History Form

Name: ____ DOB: ________________Date:______________
Medical Doctor: _____________________________ Previous Chiropractor:________________________

Section I

Present complaint (brief)____
Date started ____
Do you know what may have started it? ____
What aggravates condition/pain? ____
What lessens condition/pain? ____
Is condition worse during certain times of day? ____
Is condition interfering with work? ____
Is condition getting progressively better, worse, no change? ______________________________
Has this problem interrupted your sleep? □ Yes □ No How? _______________________________
Have you seen a doctor for this condition? ___________ When? __________________________
What tests did you have? ____
What diagnosis did they give? ____
What treatment did you receive? ____
Please list one activity that you are unable to perform or having difficulty with because of your chief problem. ____

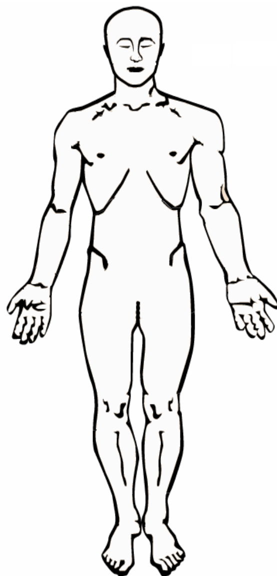
Difficulty with:	□ Standing	□ Sitting	□ Bending	□ Walking	□ Lying	□ Other
Cannot lift:	□ Light	□ Moderate	□ Heavy	□ Repetitive		
Have experienced:	□ Dizziness □ Fainting □ Headaches	□ Unsteadiness □ Pins and Needles	□ Shortness of Breath □ Bowel/Bladder Difficulty		□Chest Pain □Double Vision	

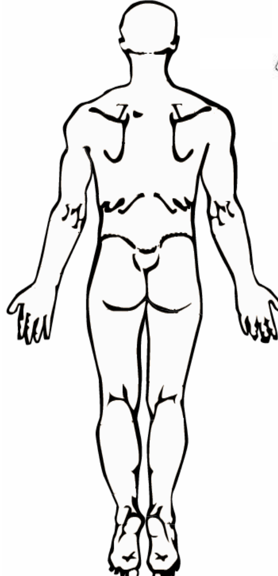
Please rate your discomfort below by indicating where your condition is at *now* with a circle.

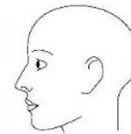
0 1 2 3 4 5 6 7 8 9 10

None **Most Severe**

Please be extreme
accurate when fill
this form. Mark th
area(s) on your bo
where you feel the
described sensatio
Use the appropria
symbol(s). Mark a
pain that travel an
include all affecte
You may draw on







Is your discomfort?

Sharp ___

Dull ___

Constant ___

On & Off ___

Section II

Did/Do you smoke? ________________________________ Do you drink pop? ____________________

Do you wear Orthotics? □ Yes □ No Past auto accidents____

Injuries? ____

____

Fractures (broken bones)?____

Teeth, eyes, or hearing problems?____

Do you have: occupational stress? ___________ physical stress?__________ mental stress?__________

Surgeries (Please list all)____

____

Current Medications ____

____

Past medical history____

____

Allergies ____

Do you have a pacemaker? (please circle) YES NO

Blood relatives with any of the following:	*Heart issues*	*Arthritis*	*Cancer*	*Diabetes*	*Other*
	____________	____________	____________	____________	____________
	____________	____________	____________	____________	____________

1. General Symptoms:

□ Headaches
□ Fatigue
□ Chills
□ Fever
□ Sinus
□ Loss of Weight
□ Allergy
□ Dizziness
□ Fainting

2. Skin:

□ Eczema
□ Skin eruptions
□ Boils
□ Hives
□ Pimples
□ Rashes
□ Dryness

3. Genito-Urinary:

□ Frequent Urination
□ Blood in urine
□ Bed wetting
□ Prostate
□ Kidney stones
□ Infection

4. Gastro-Intestinal:

□ Gas or burning sensation
□ Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Poor appetite
□ Pain in abdomen
□ Hemorrhoids
□ Jaundice

5. Respiratory:

□ Chronic cough
□ Spitting blood
□ Spitting phlegm
□ Difficulty breathing
□ Short of breath

6. Nervous System:

□ Smell
□ Taste
□ Eyes
□ Ears
□ Sense of touch
□ Muscular movements
□ Tremors
□Incoordination
□ Equilibrium

7. Female History:

□ Painful menstruation
□ Vaginal discharge
□ Regular cycle
□ Irregular cycle
□ Excessive flow
□ Menopause
□ Breast

____

To the best of my knowledge, all statements in the above Health History are true.

Signed ____ Date__________________

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Functional Rating Index

For use with **Neck and/or Back Problems** only

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

1.Pain intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care

0	1	2	3	4
No Pain; No Restrictions	Mild Pain; No Restrictions	Moderate Pain; Need to Go Slowly	Moderate Pain; Need Some Assistance	Severe Pain; Need 100% Assistance

4. Travel (driving, etc.)

0	1	2	3	4
No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short trips

5. Work

0	1	2	3	4
Can Do Usual Work; Plus, Unlimited Extra Work	Can Do Usual Work; No Extra Work	Can Do 50% of Usual Work	Can Do 25% of Usual Work	Cannot Work

6. Recreation

0	1	2	3	4
Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do a Few Activities	Cannot Do Any Activities

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain; 25% of the Day	Intermittent Pain; 50% of the Day	Frequent Pain; 75% of the Day	Constant Pain; 100% of the Day

8. Lifting

0	1	2	3	4
No Pain with Heavy Weight	Increased Pain with Heavy Weight	Increased Pain with Moderate Weight	Increased Pain with Light Weight	Increased Pain with Any Weight

9. Walking

0	1	2	3	4
No Pain; Any Distance	Increased Pain after 1 mile	Increased Pain after 1/2 mile	Increased Pain after 1/4 mile	Increased Pain with All Walking

10 Standing

0	1	2	3	4
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain after 1/2 Hour	Increased Pain with Any Standing

Name ______________________________ TOTAL SCORE ______________

PRINTED

______________________________ ______________ ______________

SIGNATURE DOB DATE

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