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: ____________________________________ D.O.B. ____________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? ____

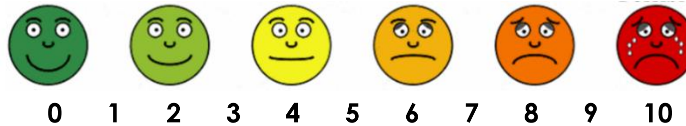
What diagnosis did they give? ____

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	

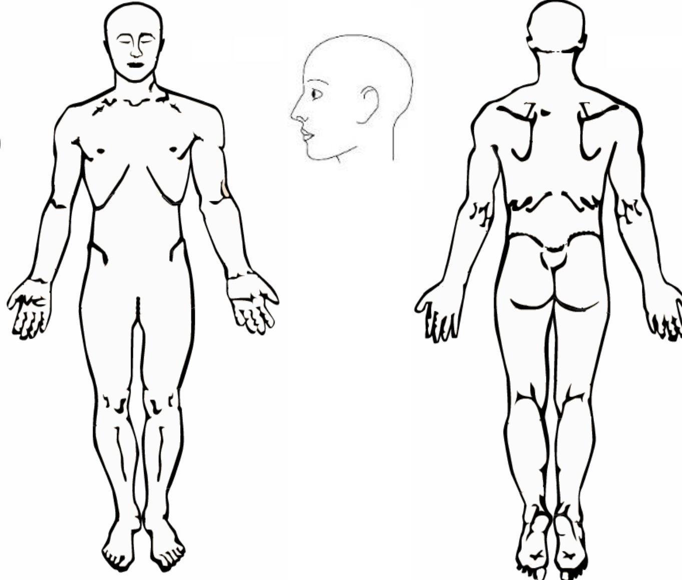
Please rate your discomfort below by indicating where your condition is at _now_ with a circle.



0 1 2 3 4 5 6 7 8 9 10

Aches: ΛΛΛΛ Numbness: oooo Pins/Needles: ●●●● Burning: XXXX Stabbing: ////

Please be extremely accurate when filling out this form. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of pain that travel and include all affected areas. You may draw on the face as well.



Is Your Discomfort:

Sharp ___

Dull ___

Constant ___

On & Off ___

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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__________________

(If patient is under 18 years, parent must sign)

Functional Rating Index

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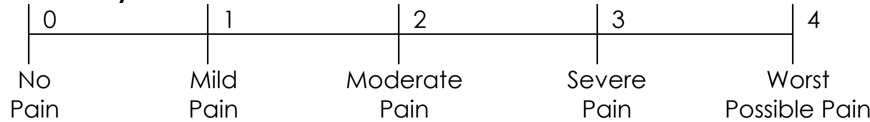
For use with **Neck and/or Back Problems** only

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.

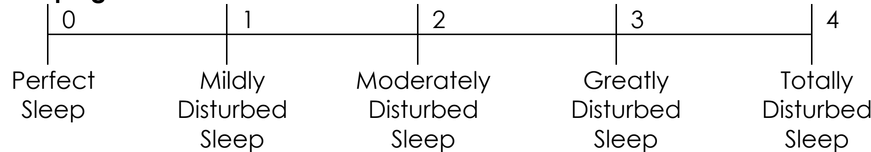
For each item below, **please circle the number which most closely describes your condition right now**.

If this is **a follow up**, please indicate on the line where your condition is **now** with an "**N**"

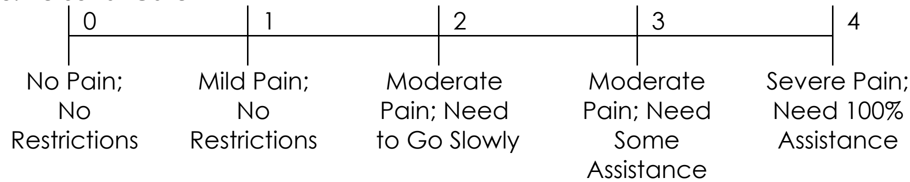
1.Pain intensity



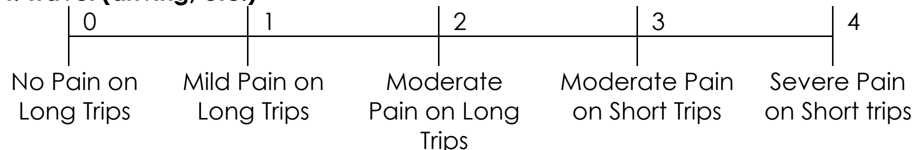
2. Sleeping



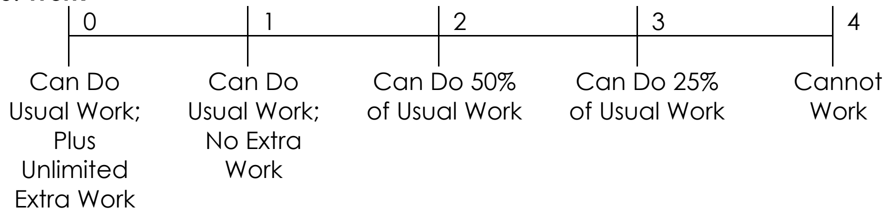
3. Personal Care



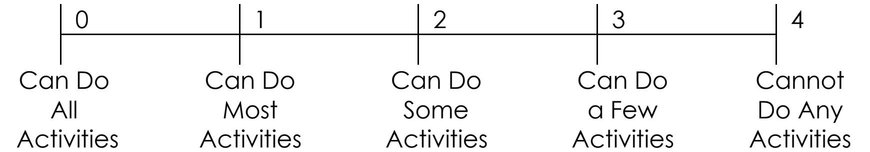
4. Travel (driving, etc.)



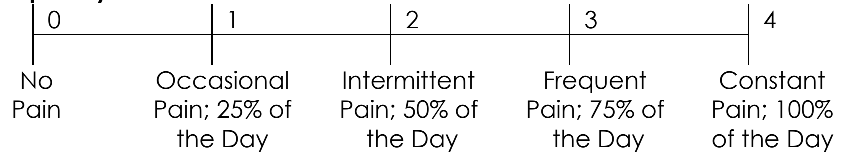
5. Work



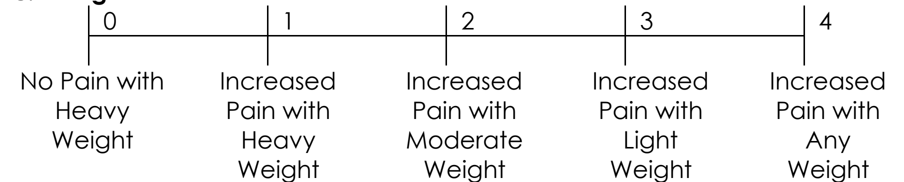
6. Recreation



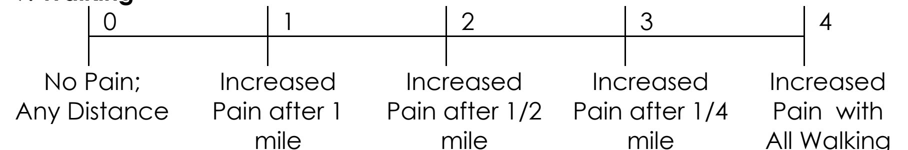
7. Frequency of Pain



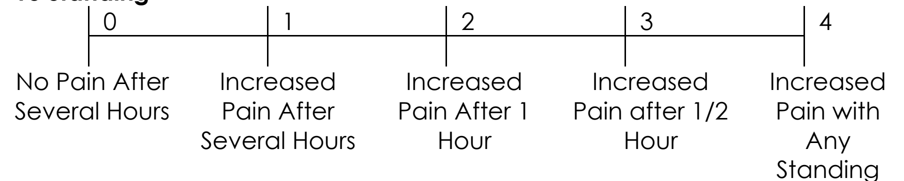
8. Lifting



9. Walking



10 Standing



Name ______________________________ ______________ TOTAL SCORE ______________

PRINTED **DOB**

______________________________ ______________

SIGNATURE **DATE**

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