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WANO CHIROPRACTIC

Rehabilitation • Weight Loss • Fitness Center

Dr. Tony Wano, DCN, FACACN
Certified Clinical Nutritionist
Dr. Katrina Whipkey, D.C.

DATE _____

PERSONAL INFORMATION ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Name _____
Address _____
City, State, Zip _____
E-mail Address _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Date of Birth _____ Age _____ Social Security Number _____
Occupation _____ Spouse Occupation _____
Employed By _____
How were you referred to our office? _____
Have you had surgery in the past? _____
Are you taking any medications? (Please List) _____
Are you pregnant? _____ How many children? _____ Are you Breast Feeding? _____

MEDICAL HISTORY

Do you or any family member have/had any of the following?

- ☐ Stroke
- ☐ Heart Attack
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Gallbladder Disease
- ☐ Kidney Disease
- ☐ Joint Disease
- ☐ Gout
- ☐ Epilepsy
- ☐ Hypoglycemia
- ☐ Anemia
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Intestine Problems
- ☐ Shortness of Breath
- ☐ High Cholesterol

Your Primary Care Physician and full address: _____
_____

HISTORY

How long have you been overweight? _____
Have you tried to lose the weight in the past? _____
Why do you want to lose weight? _____
Has your doctor recommended you lose weight? _____
Can you attribute the gain to anything? _____

FOR OFFICE USE ONLY

Height _____ Weight _____ BP _____ Goal Weight _____ Estimated Correction _____