

# Welcome to West University Wellness!

## PATIENT INFORMATION

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Sex: \_\_\_ Male \_\_\_ Female      Circle One:   Married   Single   Widowed   Divorced   Separated

## FAMILY INFORMATION

Spouse's Name: \_\_\_\_\_  
Name and # of Emergency Contact:  
\_\_\_\_\_  
Name and Ages of Children:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## WORK & INSURANCE INFORMATION

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Personal Health Insurance: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Health Insurance Card #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Customer Service #: \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

## CURRENT HEALTH CONDITION

Purpose of This Appointment: \_\_\_\_\_  
Other Doctor(s) Seen For This Condition:    Yes    No    Whom? \_\_\_\_\_  
When did this start? \_\_\_\_\_ What Treatment Have You Had? \_\_\_\_\_  
Has This Condition Occurred Before?    Yes    No    If yes, then when? \_\_\_\_\_  
List Any Medications You Are Taking: \_\_\_\_\_

## TYPE OF INJURY

Is Condition (circle one):   Job Related   Auto-Accident  
Home Injury   Fall   Other: \_\_\_\_\_  
Date of Injury/Accident: \_\_\_\_\_  
Time of Injury/Accident: \_\_\_\_\_  
Have You Made A Report of Your Accident To Your  
Employer?        Yes        No

## PAST MEDICAL HISTORY

Major Surgeries/Operations/ Hospitalizations:  
\_\_\_\_\_  
\_\_\_\_\_  
Previous Chiropractic Care:    Yes    No  
If yes, Dr.'s name and last visit:  
\_\_\_\_\_

We have alliances with other small businesses in the local area. Would you be interested in any of the following services?

- |  |  |   |   |   |   |
|--|--|---|---|---|---|
| <input type="checkbox"/> Banker            | <input type="checkbox"/> Construction & Design | <input type="checkbox"/> Gift baskets     | <input type="checkbox"/> Marketing        | <input type="checkbox"/> Printing             | <input type="checkbox"/> Realtor                |
| <input type="checkbox"/> Business Attorney | <input type="checkbox"/> CPA                   | <input type="checkbox"/> Health Insurance | <input type="checkbox"/> Massage Therapy  | <input type="checkbox"/> Probate law          | <input type="checkbox"/> Sales Training         |
| <input type="checkbox"/> Catering          | <input type="checkbox"/> Credit card svcs.     | <input type="checkbox"/> Home Mortgage    | <input type="checkbox"/> Office furniture | <input type="checkbox"/> Property Insurance   | <input type="checkbox"/> Skin Care              |
| <input type="checkbox"/> Computer support  | <input type="checkbox"/> Financial Planning    | <input type="checkbox"/> Interior design  | <input type="checkbox"/> Office supplies  | <input type="checkbox"/> Private Investigator | <input type="checkbox"/> Supplemental Insurance |
|  |  | <input type="checkbox"/> Life Insurance   | <input type="checkbox"/> Payroll Services | <input type="checkbox"/> Promotional Products | <input type="checkbox"/> Telephone Systems      |

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |                                      |   |  |                                      |
|--------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Anemia      | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Pneumonia       | <b>INTAKE</b>                        |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Influenza        | <input type="checkbox"/> Polio           | <input type="checkbox"/> Coffee      |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Lumbago          | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tea         |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles          | <input type="checkbox"/> Small Pox       | <input type="checkbox"/> Sodas       |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Mental disorders | <input type="checkbox"/> Thyroid         | <input type="checkbox"/> Alcohol     |
| <input type="checkbox"/> Eczema      | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Cigarettes  |
| <input type="checkbox"/> Epilepsy    | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> White Sugar |

Are you HIV positive?  Yes  No

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:**

**MUSCULO-SKELETAL**

- Neck Pain
- Headaches
- Pain Between Shoulders
- Low Back Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

**NERVOUS SYSTEM**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

**GENERAL**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

**GASTRO-INTESTINAL**

- Poor Appetite
- Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gallbladder Problems
- Weight Trouble
- Abdominal Cramps

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

**GENITO-URINARY**

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine
- Urinary Tract Infections

**CARDIOVASCULAR**

- Chest Pain
- Short of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke
- High Cholesterol

**EENT**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Sinus Congestion

**MALE/FEMALE**

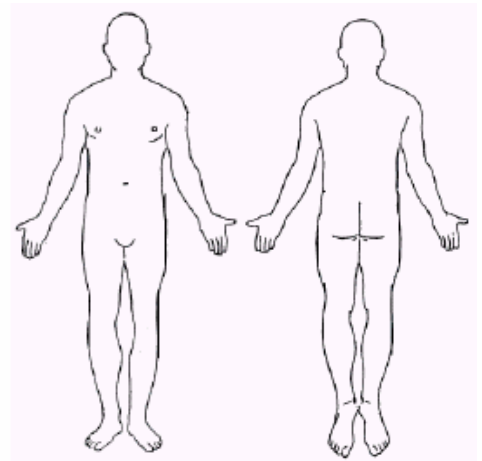
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate Problems
- Infertility
- Sexual Dysfunction
- Other Problems

**FEMALES ONLY**

When was your last period?

Are you pregnant?

- Yes  No  Not Sure



Please outline on the diagram the area of your discomfort

**FAMILY HISTORY**

The following members have the same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child