NEW CLIENT INFORMATION

Today's Date________________

PERSONAL INFORMATION

Name: ____ Age: _________ Date of Birth: ____________________________

Nickname or preferred name: ____

Home / Mailing Address: __________________________ City: ____________________ State: _______ Zip: _____________

Home Phone: (_____) _________________________ Cell Phone: (_____) _____________________________

email address: ____ Soc. Sec. # (if req. for insurance) ________________

Occupation: _________________________________ Employer / School: _____________________________________

Work Phone: (_____) __________________________ Work Status: ☐Full-time ☐Part-time ☐Seasonal ☐Other

In case of an Emergency – Contact: ________________________________ Relationship: _____________________________

Home Phone: (_____) _________________________ Cell Phone: (_____) _____________________________

Marital Status: ☐S ☐M ☐D ☐W ☐ Other Number of Children (if any) & ages: ___________________________

Most of our patients are referred to us by a caring family or friend. Whom may we thank for referring you to our office? Or how did you hear about us? ____

Do you have a Primary Care Physician? ☐Y ☐N Would you like Functional Wellness to provide progress reports or information to your PCP or other practitioners? If yes: Full Name of Practitioner ____

HEALTH INFORMATION

HEALTH CONCERNS: Please list your top health concerns / complaints that you would like to address (in order of priority):

1) ____

2) ____

3) ____

Is this concern affecting your quality of life? (Please circle only those applicable to you)

Work / School:	Y	N	Recreation:	Y	N	Sleep:	Y	N
Exercise / sports:	Y	N	Walking:	Y	N	Sitting:	Y	N
Eating:	Y	N	Intimate/Personal Life:	Y	N	Other:	Y	N

HEALTH CARE PRACTITIONER HISTORY:

Have you ever received Chiropractic care? ☐Y ☐N When: ____

Where: __________________________ Doctor(s) name(s): ____

How long under care: ______________ Date of last visit: ____________ Why did you stop? ________________________

Was there a particular health concern(s) for which you consulted the chiropractor? ______________________________________

Did you find the treatments helpful?____

Have you consulted or do you regularly consult any of the following care providers? (check all that apply)

☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐Homeopath

☐ Massage Therapist ☐ Psychotherapist ☐ Physical Therapist ☐Dentist

☐ Nutritionist ☐ Personal Trainer ☐ Other: ____________________

Comments (conditions, treatments, success, etc.) ____________________

____

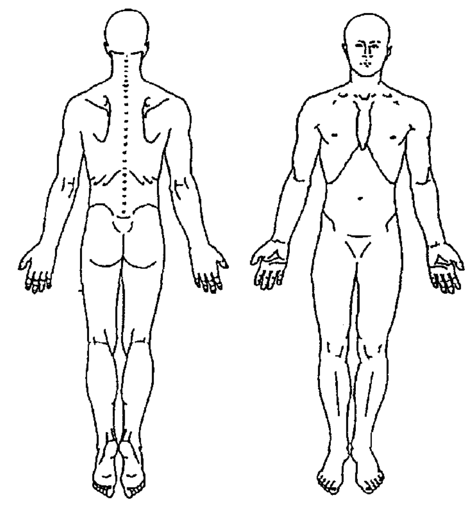
____

MEDICAL HISTORY: – Please check all that apply (P = Past / C = Current):

P / C		P / C		P / C	
☐ ☐	Abdominal Pains	☐ ☐	Frequent Urination	☐ ☐	Rapid Heart Rate
☐ ☐	Ankle/Foot Pain	☐ ☐	Fullness of Bladder	☐ ☐	Shakiness
☐ ☐	Blurred Vision	☐ ☐	Headache	☐ ☐	Shoulder Pain
☐ ☐	Chest Pressure	☐ ☐	Hemorrhoids	☐ ☐	Sinusitis
☐ ☐	Clammy Hands	☐ ☐	High Blood Pressure	☐ ☐	Slow Heart Rate
☐ ☐	Confusion	☐ ☐	Hip Pain	☐ ☐	Sore Muscles
☐ ☐	Constipation	☐ ☐	Insomnia	☐ ☐	Sore Throat
☐ ☐	Convulsions	☐ ☐	Irritability	☐ ☐	Swallowing Pain
☐ ☐	Decreased Sex Drive	☐ ☐	Joint Stiffness	☐ ☐	Sweating
☐ ☐	Dizziness	☐ ☐	Knee Pain	☐ ☐	Swollen Ankles
☐ ☐	Dry Mouth	☐ ☐	Low Back Pain	☐ ☐	Swollen Joints
☐ ☐	Earache	☐ ☐	Low Blood Pressure	☐ ☐	Teeth Grinding
☐ ☐	Elbow/Hand Pain	☐ ☐	Lump in Throat	☐ ☐	Tingling in Feet
☐ ☐	Excessive Thirst	☐ ☐	Menstrual Irregularities	☐ ☐	Tingling in Hands
☐ ☐	Eye Pain	☐ ☐	Nausea/Vomiting	☐ ☐	Urination Difficulty
☐ ☐	Facial Pain	☐ ☐	Neck Pain	☐ ☐	Walking Problems
☐ ☐	Fainting	☐ ☐	Paralysis	☐ ☐	Weak Muscles
☐ ☐	Fatigue	☐ ☐	Persistent Coughing	☐ ☐	Other:__________
☐ ☐	Feel Loss of Control	☐ ☐	Poor Appetite		__________
☐ ☐	Forgetfulness	☐ ☐	Poor Circulation		__________

Please use the legend below to indicate any areas in which you feel the listed sensations

Stabbing - ||| Tingling - :::
Burning – XXX Cramping - ^^^
Numbness - === Dull / Ache - ###



Women only: # of pregnancies: ________ # of birth children: ________ # of C-Sections: ________

Age of children (if any): ________ Breast fed? ☐Y ☐N How long (each child) ? ________

Age of menarche (periods began): ________ Are you experiencing perimenopause? ☐Y/☐N Reached Menopause ☐Y/☐N

Is there any chance you might be pregnant? ☐Y ☐N Date of last menstrual cycle: ________

Do you currently, or have you used any of the following? (please circle all that apply) Birth Control Pills, Hormone Replacement Therapy, Hormone IUD, Copper IUD, Contraceptive Shot (ex. Depo), Vaginal Ring, Contraceptive Patch, Emergency Contraceptive

Length of use of each type ? ________ Have you ever had an abnormal PAP? ☐Y ☐N

HEALTH & FAMILY HISTORY:

Height:________ Weight:________ Recent Weight Loss / Gain? ________

Reason / method for weight loss / gain: ________

Difficulty falling asleep? ☐Y ☐N Difficulty staying asleep? ☐Y ☐N Tired after full night's sleep? ☐Y ☐N

Crave sugar / salt? ☐Y ☐N Fatigue after meals? ☐Y ☐N Lightheaded / irritable when hungry? ☐Y ☐N

Need coffee / sweets 3-4pm? ☐Y ☐N Do you eat Breakfast? ☐Y ☐N Usual breakfast foods:________

What time do you eat Breakfast? ________ What time do you eat Lunch? ________

What time do you eat Dinner? ________ Do you eat snacks? ☐Y/☐N Types:________

Identify any conditions that you, or any of your family members have now or have had in the past:
(X = Self, G = Grandparents, M = Mother, F = Father, S = Siblings)

___Alcoholism	___Eczema/Psoriasis	___Hepatitis A/B/C	___ Stroke
___Anemia	___Emphysema	___Herpes	___ Tumor(s)
___Cancer	___Epilepsy	___High Blood Pressure	___ Ulcer(s)
___Cold sores	___Goiter	___ Mumps	Other: ____________________
___Deep vein thrombosis	___Gout	___ Pleurisy	____________________
___Depression/Anxiety	___Heart disease	___ Pneumonia	____________________
___Diabetes	___HIV/AIDS	___ Polio	

Do you wear corrective lenses? ☐Y ☐N Date of last check-up / prescription change? ______________________________

Physical, chemical, structural and emotional stresses, common to our contemporary lifestyles, can result in dysfunction of the areas surrounding and involving the nervous system (the body's primary system which co-ordinates health}. The following may be seemingly insignificant events, however they may be contributing to today's experiences of health and wellbeing. Please feel free to add anything not listed here, and to ask any questions you may have regarding this section.

ACCIDENTS: Have you had any accidents related to any of the following? (check all that apply)

☐Automobile ☐Motorcycle ☐Bicycle ☐Sports ☐Playground ☐Abuse ☐Other

Year (approximate)	Please describe (injuries, treatment, outcome)

INJURIES: Have you ever injured any of the following regions? (check all that apply)

☐Head ☐Neck ☐Rib/Chest ☐Back ☐Pelvis/Hip ☐Arm/Hand ☐Leg/Foot

Year (approximate)	Please describe (injuries, treatment, outcome)

HOSPITALIZATIONS / SURGERIES: Please detail any hospitalizations, serious illnesses or surgeries

Year	Reason	Hospital	Outcome

MEDICATIONS: Please list all medications you are currently taking (prescribed or over-the-counter)

Medication Name	Condition	Date Started	Who Prescribed?

NUTRITIONAL SUPPLEMENTS: Please list all Vitamins and Nutritional supplements you are currently taking

Supplement	Brand and Amount Consumed	Date Started	Prescribed by anyone?

ALLERGIES: Please check and list all allergies

☐ Food: ______________________________

☐ Medications: ______________________________

☐ Seasonal/Latex/Other: ______________________________

HABITS: Please include current and previous amounts

	Daily	Weekly	Monthly	Never
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda/Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Rec. Drugs	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Exercise	☐	☐	☐	☐	________	________
	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs	
Sleep	☐	☐	☐	☐	☐	
	5+	4	3	2		
Meals/day	☐	☐	☐	☐		
	8+ cups	4-7 cups	2-4 cups	<8 oz		
Water/day	☐	☐	☐	☐		

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking/Moving ☐ Driving

STRESS LEVEL: ☐ Very High ☐ High ☐ Medium ☐ Low

If you have any concerns or questions you would like to note here, or issues you think might be related to your condition please do not hesitate to discuss any matter with Dr. Jacqui prior to, during or after your appointment.

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______________________ ______________________ ______________________
Patient Name Printed Patient Signature Date

______________________ ______________________
Parent and/or Guardian Printed Parent and/or Guardian Signature