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The Wellness Center

PERSONAL INFORMATION

Today's Date _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ Work Phone _____

Cell Phone _____ E-mail address _____

Date of Birth _____ Age _____ SS # _____

Employer _____ Occupation _____

Insurance Information

Insurance Company _____

Policyholder Name _____ SS # _____

Policyholder Date of Birth _____ Group # _____

Policy Number _____ Insurance Phone Number _____

Doctor Information

Primary Care Doctor _____ Phone Number _____

Referring doctor/other physicians you currently see

_____

Referring doctor/other physicians phone number

_____

Contact Person

Name _____ Phone Number _____

How did you hear about us?

_____

(Please state which magazine, newspaper, doctor, etc.)

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HEALTH HISTORY

Name _____

Male _____ Female _____ Height _____ Weight _____

For what problem are you seeking care? _____

How long has it been present? _____

Have you sought any treatment or therapy? _____

If pain is present, please describe: How often _____

Severity (1 = minimal to 10 = severe) _____

Quality (sharp, dull, cramps, burning, etc) _____

What makes pain better? _____

What makes pain worse? _____

ALLERGIES: Are you allergic to:

Any foods No Yes

Any drug allergies No Yes

If so please list _____

Do you smoke? No Yes

If Yes_____Packs Per Day

List all **medications** you now take, the dose, and how often:

Medication Dose/Frequency

1 _____ 4_____

2 _____ 5_____

3 _____ 6_____

Check and/or list all **illnesses / injuries** you have been treated for in the past and at present:

___ Heart attack ___ Angina ___ Seizures ___ Arthritis

___ Heart murmur ___ Mitral valve prolapse ___ High blood pressure ___ Diabetes

___ Stroke ___ Asthma ___ Ulcerative colitis ___ Cancer

___ Blood clots ___ Bleeding disorder ___ Hepatitis ___ COPD

___ Kidney problems ___ Phlebitis ____Auto Injury

Other Illnesses:_____

Other Injuries: _____

List all **surgeries** you have had:

_____

_____

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HEALTH HISTORY Cont.

Family History

Is there a family history of these diseases? (circle) diabetes, arthritis, sickle cell, foot problems, heart or lung problems, cancer, keloid scars. Other: _____

Social History

Do you drink alcoholic beverages? Yes No How much per week? _____

Do you exercise regularly? Yes No Type of exercise? _____

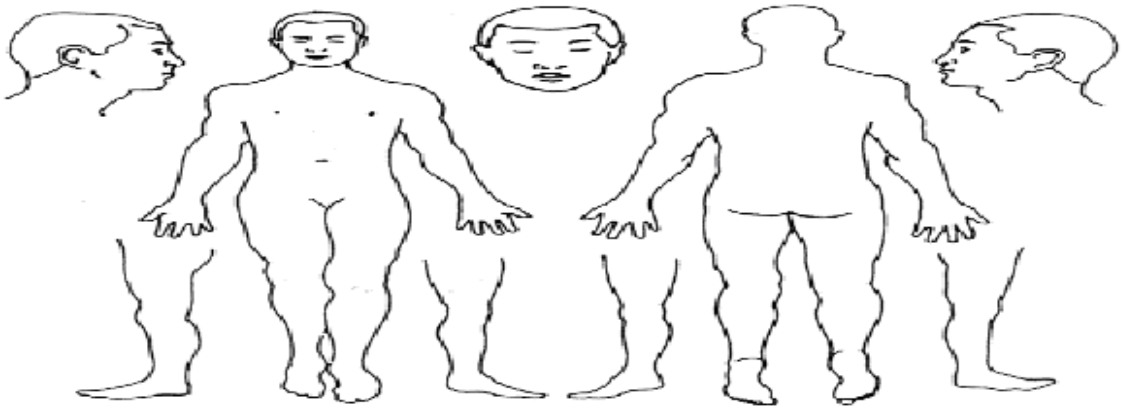
Women: Number of children ____ Are you pregnant? Yes No # of months pregnant? _____

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____Number of days of flow_____

Color of flow:	**Amount of flow:**	**# of pads you use per day:**	**Pain and cramping:**
□ pale/light red	□ spotting	1st day ___	□ No
□ red	□ light	2ND day ___	□ Yes
□ bright red	□ even throughout	3RD day ___	□ before flow
□ dark red	□ heavy	4th day ___	□ during flow
□ dark red/brown	□ clots	+days ___	□ after flow
			□ moderate
			□ mild
			□ severe

Please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain:

□ dull/achy □ sharp/stabbing □ burning □ tingling □ numbness □ electrical