Gentle Touch CHIROPRACTIC & Wellness Center
Wellness from the Inside Out

Foundation for Wellness PROFESSIONALS™
A National Non-profit Foundation

Name: _____Date of Birth:_____

Address: _____

City: _____ State: ___ Zip: _____

Cell Phone: _____ Home Phone:_____

E-mail address: _____

Are you on Medicare? _____

Emergency Contact Name: _____ Emergency Phone: _____

Occupation: _____#hrs./week currently working: _____

Spouse Occupation: _____#hrs./week currently working: _____

Have you ever been in a fender bender? _____
Date of your most recent fender-bender_____

Other accidents? Please explain_____

HEALTH INFORMATION:

Describe your **major** health concern? _____
When did this health concern begin to bother you? _____
Anything make the complaint feel **better** (i.e. Ice, heat, rest)? _____
Anything make the complaint feel **worse** (i.e. Driving, standing, sitting)? _____
Regarding the **pain**, check all that apply:

_____constant pain	____very severe	____Dull, Ach	_____Throbbing
_____frequent pain	____severe	_____Stabbing, Sharp, Shooting	_____Crawling
_____intermittent pain	____moderate	_____Excruciating	_____Stinging
_____occasional pain	____mild	_____Pins and Needles	_____Numbness

Other health conditions which concern you?

_____

B. MEDICAL HISTORY:

List **ALL** medications, over the counter drugs, and vitamins you currently take:

1._____ 2._____ 3._____
4._____ 5._____ 6._____
7._____ 8._____ 9._____
10._____11._____12._____

Have you ever been hospitalized or had surgery of any kind? _____

Have any organs been removed from your body i.e. Appendix, Tonsils, Adenoids, Gallbladder?
_____
_____

Do you suffer from any of the symptoms listed below **frequently** (check all that apply)?

_____Headaches	_____Upset Stomach	_____Difficulty Breathing
_____Neck Pain/Stiffness	_____Diarrhea	_____Asthma
_____Low Back Pain	_____Constipation	_____Excessive and Dry Cough
_____Chest/Heart Trouble	_____Excessive Thirst	_____Excessive Cough with Mucus Production
_____Cold Hands/Feet	_____ Hemorrhoids	_____Painful Urination
_____Depression	_____Nervousness	_____Excessive Urination
_____Fatigue	_____ Stress/Tension	_____Loss of Balance/Dizzy
_____Difficulty Swallowing	_____ Sleeplessness	_____Ringing in the Ears
_____Heart Burn	____ Easy Bruising	_____Loss of Memory, Smell or Taste (circle)

Who is your primary health care provider (i.e. Medical Doctor)? _____

Do you or anyone in your immediate family suffer from any of these diseases (check all that apply)?

_____Diabetes _____Heart Disease _____High Blood Pressure_____ Cancer _____Any other major disease

C. ADDITIONAL INFORMATION:

Describe in detail how your condition affects your day to day living? For example do you avoid certain work/ recreational activities? Is it affecting your ability to sleep?
_____
_____
_____
_____

Is your condition due to a _____Automobile Accident _____Job Injury _____Other?

If so please describe **in detail** what happened during the accident/ traumatic event:
_____
_____
_____
_____

Describe **in detail** your specific health goal(s):

_____
_____
_____
_____

How did you hear about us? _____Massage Event _____Health Talk _____Patient Referral _____Internet
_____Gift Certificate _____Health Fair _____Dinner Event

Other (please specify) _____

D. <u>SERVICES OFFERED AND POLICIES</u>:

At Gentle Touch Chiropractic and Wellness Center we offer the following methods to restore vitality:

1. Gentle Chiropractic Adjustments
2. Medical Acupuncture
3. Nutrition Therapy
4. Hydrotherapy Massage

There are three things you need to know about our office before you agree to the consultation:

1.We don't prescribe drugs or dispense medication.
2.We don't perform surgery.
3.We don't accept every patient who comes to us for help.

By signing this form I agree to a consultation. I have read and understood the above listed services offered and policies outlined.

NAME_____**SIGNATURE**_____**DATE**_____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature