

**Why This Form Is Important**

As a Creating Wellness Center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological stresses that can accumulate and result in serious loss of health potential. Answering the following questions will give us a profile of the specific stresses that you face and allow us to better assess the challenges to your health potential and the functioning of your nervous system, which is the essence of chiropractic.

**Personal Information**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY / STATE / ZIP: \_\_\_\_\_

HOME #: \_\_\_\_\_ CELL #: \_\_\_\_\_ WORK #: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SINGLE: \_\_\_\_\_ MARRIED: \_\_\_\_\_ DIVORCED: \_\_\_\_\_ WIDOWED: \_\_\_\_\_

NUMBER OF CHILDREN (INCLUDE AGES): \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYER'S NAME & ADDRESS: \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

**Your Main Concern(s)**

Briefly explain why you came to this Creating Wellness office: \_\_\_\_\_  
\_\_\_\_\_

**Symptoms and Concerns**

*(If you have no symptoms or complaints, please skip to "General Health" section on the next page)*

| List your health concerns and/or any symptoms: | Rate of Severity<br>1 = mild<br>10 = worst | Are symptoms constant or intermittent? | If you have pain, please describe it: (dull, sharp, etc.) | When did this episode begin? |
|--|--|--|---|------------------------------|
| 1. _____                                       | _____                                      | _____                                  | _____   | _____                        |
| 2. _____                                       | _____                                      | _____                                  | _____   | _____                        |
| 3. _____                                       | _____                                      | _____                                  | _____   | _____                        |

Is the condition(s) interfering with: work, sleep, leisure, sports, exercise, walking, hobbies or attitude?

Why do you think your body has not been able to heal itself or overcome the problem? \_\_\_\_\_  
\_\_\_\_\_

If your symptoms went away, would you then consider yourself healthy? \_\_\_\_\_

Please list other practitioners or doctors seen for this condition:

Name/location: \_\_\_\_\_ Date: \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_ What was done? \_\_\_\_\_

## General Health and Wellness

On a scale of 1-10, please rank your psychological/emotional stress levels in each category

(1= none/ 10= extreme):      Occupational: \_\_\_\_\_      Personal: \_\_\_\_\_

On a scale of 1-10 (1= poor/ 10= excellent), please describe your:

Eating habits: \_\_\_\_\_      Exercise habits: \_\_\_\_\_      Sleep: \_\_\_\_\_

General Health: \_\_\_\_\_      Mind-set: \_\_\_\_\_

Please list your unhealthy lifestyle habits (ie. smoking, eating junk food): \_\_\_\_\_

What is your present level of commitment to address any underlying causes of your symptoms and health conditions that relate to your lifestyle (on a scale of 1-10, 10 being 100% committed)? \_\_\_\_\_

Have you ever seen a chiropractor? \_\_\_\_\_ If yes, what was your experience like? \_\_\_\_\_

Please list any medications and/or nutritional supplements (i.e. vitamins, calcium, herbs) that you currently take and why: \_\_\_\_\_

Have you been diagnosed with a medical condition or illness (please explain any and all)? \_\_\_\_\_

Please mark (X) all symptoms you have experienced in the past four (4) months, even if they do not seem related to your current problem:

|   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> headaches                | <input type="checkbox"/> pins and needles in legs | <input type="checkbox"/> fainting         | <input type="checkbox"/> neck pain       |
| <input type="checkbox"/> pins and needles in arms | <input type="checkbox"/> loss of smell            | <input type="checkbox"/> back pain        | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> dizziness                | <input type="checkbox"/> buzzing in ears          | <input type="checkbox"/> ringing in ears  | <input type="checkbox"/> nervousness     |
| <input type="checkbox"/> numbness in fingers      | <input type="checkbox"/> numbness in toes         | <input type="checkbox"/> loss of taste    | <input type="checkbox"/> stomach upset   |
| <input type="checkbox"/> fatigue                  | <input type="checkbox"/> depression               | <input type="checkbox"/> irritability     | <input type="checkbox"/> tension         |
| <input type="checkbox"/> sleeping problems        | <input type="checkbox"/> stiff neck               | <input type="checkbox"/> cold hands       | <input type="checkbox"/> cold feet       |
| <input type="checkbox"/> diarrhea                 | <input type="checkbox"/> constipation             | <input type="checkbox"/> fever            | <input type="checkbox"/> hot flashes     |
| <input type="checkbox"/> cold sweats              | <input type="checkbox"/> lights bother eyes       | <input type="checkbox"/> urinary problems | <input type="checkbox"/> heartburn       |
| <input type="checkbox"/> mood swings              | <input type="checkbox"/> menstrual irregularity   | <input type="checkbox"/> menstrual pain   | <input type="checkbox"/> ulcers          |

Do you wear orthotics or heel lifts?

Have you had x-rays taken? \_\_\_\_\_ If yes, when and what area of the body? \_\_\_\_\_

Have you had any surgeries?

1. Type: \_\_\_\_\_ Year: \_\_\_\_\_
2. Type: \_\_\_\_\_ Year: \_\_\_\_\_
3. Type: \_\_\_\_\_ Year: \_\_\_\_\_

Have you had any accidents, injuries or traumas from birth to present? (falls, auto, work-related, etc.)

1. Type: \_\_\_\_\_ Year: \_\_\_\_\_
2. Type: \_\_\_\_\_ Year: \_\_\_\_\_
3. Type: \_\_\_\_\_ Year: \_\_\_\_\_
4. Type: \_\_\_\_\_ Year: \_\_\_\_\_

If there is a need for dietary changes to help you achieve a greater level of wellness, would you like to be informed? Yes    No

If there is a need for specific exercises, would you like to be informed? Yes    No

If there is a need for support in the psychological/mind/body/stress dimension of health, would you like to be informed? Yes    No

Would you like to be informed of what nutritional supplements or foods may help address your current health concerns or symptoms? Yes    No

I consent to a professional and complete chiropractic examination. I agree to pay one-half of the total fee for today's services at the conclusion of this visit, and I understand that I am ultimately responsible for any fees for services rendered in this office.

I understand I am financially responsible, *whether or not my insurance company pays*, for all charges incurred by me. I hereby assign my major medical insurance benefits, private insurance and other health plans (excluding Medicare) to Douglas Matzner, D.C. Any overpayment will be promptly refunded. I also authorize Douglas Matzner, D.C. to release any information needed to secure payment. If my balance becomes delinquent and suit is filed, I agree to pay all collection costs including attorney fees and court costs. Accounts over 60 days delinquent may be subjected to a monthly finance charge of 1.5%, or 18% annually.

**I understand that if I do not notify your office in advance, I will be charged a missed appointment fee equivalent to one office visit.** This fee will not be billed to my insurance, work compensation carrier or attorney, but is due and payable by me directly before any further services are rendered. I have read, understand, and agree to comply with the above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Thank you for filling out this form and taking your first step to **Creating Wellness!***