Excelsior HEALTH CENTER

New Client Information Form

About You

Today's Date: _____ / _____ / _____

Name: _____

What do you prefer to be called? _____ ■ Male ☐ Female

Birth Date: _____ / _____ / _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____

Home Phone: _____ Other Phone: _____

Referred by: _____

Occupation: _____ Work Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Reason for visit

Have you ever seen a chiropractor before? _____ Y/N

If so, please explain: _____

The reason for this visit is a result of: ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Other ☐ Chronic

Explain what happened: _____

Please describe the pain and it's location: _____

When did this condition begin? _____

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine

If so, please explain: _____

Have you had this or similar conditions in the past? _____ Y/N

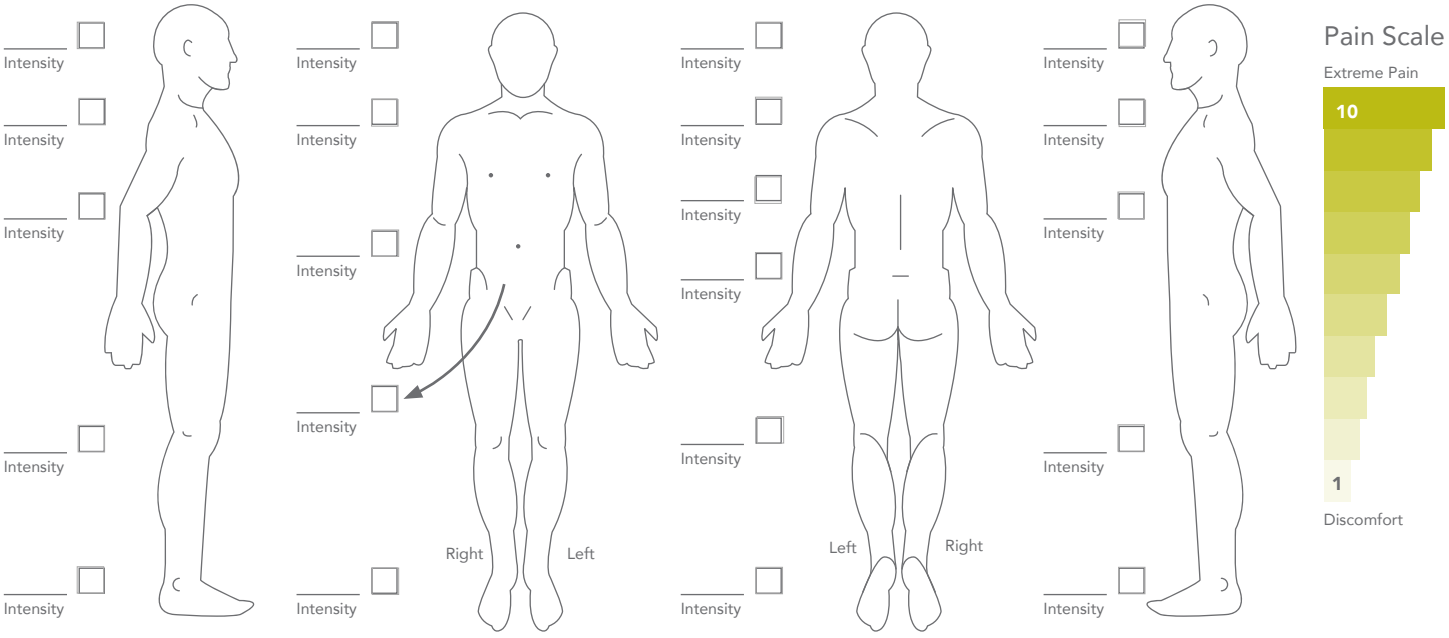
If so, please explain: _____

Have you been treated by a Medical Physician for this condition? _____ Y/N

If so, please explain: _____

Description of Physical Problems

Please check the box closest to the area(s) of injury or discomfort and fill in the intensity level for that area.



Right Front Back Left

Additional Information You Wish to Provide

Essential Health Information

Indicate the frequency of your symptoms using the following numbers:
1 = Rarely 2 = From time to time 3 = Often

Patient Name _____

Date _____ / _____ / _____

Section A

_____ Lower bowel gas several hours after eating
_____ Burning stomach sensation, eating relieves
_____ Coated tongue
_____ Indigestion 1/2 - 1 hr after eating (up to 3-4 hours after)
_____ 3+ carbonated drinks per week
_____ Difficult bowel movements
_____ Ulcers? / Colitis? / Gastritis?
_____ Stomach bloating after eating
_____ Excessive belching/burping
_____ Bad breath
_____ Alternating diarrhea/constipation
_____ Have pets (dogs, cats, farm animals, etc)
_____ Rectal itching
_____ Can't gain weight
_____ International travel
_____ Stomach/intestinal cramping/diarrhea

Section B

_____ Afternoon headaches
_____ Get "shaky" if hungry
_____ Faintness if meals delayed
_____ Heart palpitates if meals missed or delayed
_____ Eat when nervous
_____ Awaken after few hours of sleep
_____ Hard to get back to sleep
_____ Crave candy of coffee in afternoon
_____ Abnormal craving for sweets or snacks
_____ Thirsty much of the time
_____ History of diabetes
_____ Blurred vision/failing eyesight
_____ Breath smells sweet
_____ Tingling, numbness, prickling sensation in extremities

Section C

_____ Bruise easily, "black & blue" spots
_____ Sigh frequently
_____ Aware of "breathing heavily"
_____ Open window in closed room
_____ Suceptible to colds & fevers
_____ Swollen ankles, worse at night
_____ Muscle cramps, worse during night
_____ Shortness of breath on exertion
_____ Nosebleeds
_____ Ringing in the ears
_____ Heart palpitations
_____ Dull pain in chest/radiating into left arm (worse on exertion)
_____ Hands & feet go to sleep easily
_____ Numbness in extremities
_____ Tendency to anemia
_____ Tension under breastbone or feeling tightness (worse on exertion)
_____ Blushing with no apparent cause
_____ Black stool (no iron supplementation)
_____ Poor concentration
_____ Slurred speech
_____ Headaches
_____ Weakness/fatigue
_____ Out of breath frequently e.g. going up stairs
_____ Nervousness

Essential Health Information

Section D

_____ Pain under right side of rib cage
_____ Skin rashes frequent
_____ Bitter metallic taste in mouth in morning
_____ Bowel movements painful or difficult
_____ Low energy, weakness, exhaustion
_____ Greasy/fatty foods upset stomach
_____ Bruises easily
_____ Frequent headaches
_____ Stool is light colored
_____ Pain between shoulder blades
_____ Laxatives used often
_____ History of gallbladder attacks or gallstones
_____ History of heaptitis
_____ History of jaundice
_____ Sneezing attacks
_____ Itchy skin, worse at night
_____ Dry, flaky skin, hair
_____ General feeling of poor health
_____ Aching muscles
_____ Swollen feet and/or legs

Section E

_____ Impaired hearing
_____ Decrease in appetite
_____ Ringing in ears
_____ Constipation
_____ Puffy hands/face
_____ Tired/sluggish
_____ Miscarriages
_____ Infertility
_____ Mental sluggishness/forgetfulness
_____ Headache upon rising; wears off during day
_____ Slow pulse, below 65
_____ Cold hands and feet
_____ Gains weight easily
_____ Weight gain around hips
_____ Outer third of eyebrow thinning
_____ "Emotional"
_____ Flush easily
_____ Night sweats
_____ Hair loss

Section F

_____ Hip and joint pain
_____ Receding gums and/or dental cavities
_____ Tendency towards slouching/weak
_____ Bone loss/osteoperosis in family
_____ Crunching, creaking joints

Section G

_____ Exposure to fumes (paint, salon, car)
_____ Use pesticides on garden
_____ Live near power lines / high tension wires
_____ Have mercury amalgams (silver) in mouth
_____ Skin disorders (psoriasis, eczema, etc.)
_____ Loss of hair
_____ Hormone disorders
_____ History of cancer/personal or familial

Essential Health Information

Section H

_____ Muscle aches, stiffness, cramping and pains
_____ Chiropractic adjustments don't hold
_____ Whiplash and/or ligament trauma/strain
_____ Fatigue, sluggishness
_____ Upper or lower back pain
_____ Stiff neck and shoulders

Section I

_____ Low blood pressure
_____ Chronic fatigue
_____ Low energy, lack of stamina
_____ General malaise, unhappiness
_____ Tendency to hives
_____ Arthritic tendency
_____ Excessive perspiration
_____ Colds/flu often
_____ Weakness after illness
_____ Dark circles under the eyes
_____ Crave salty foods
_____ Feeling unrefreshed upon waking
_____ Allergies
_____ Exhaustion - muscular & nervous
_____ Respiratory disorders
_____ Swollen ankles
_____ Dizzy when stand up "too fast"
_____ Decreasing appetite
_____ Irritable
_____ Bright lights irritate

Section J

Female only

_____ Painful menses
_____ Premenstrual tension
_____Very easily fatigued
_____ Depressed feeling
_____ Menstruation excessive and prolonged
_____ Painful breasts (monthly)
_____ Lumpy breasts, worse at menses
_____ Have taken birth control pills
_____ Menopause, hot flashes, etc.
_____ Menses scantly or irregular
_____ Acne, worse at menses
_____ Vaginal discharge/yeast etc.

Male only

_____ Tired too easily
_____ Urination difficult
_____ Night urination frequent
_____ Pain on inside of legs or heel
_____ Feeling of incomplete bowel evacuation
_____ Prostate trouble
_____ Leg nervousness at night
_____ Diminished sex drive

Essential Health Information

Section M

_____ Chronic urination
_____ Rose colored (bloody) urine
_____ Dripping after urination
_____ Difficulty passing urine
_____ Cloudy urine
_____ Rarely need to urinate
_____ Frequent bladder infections
_____ Painful/burning when urinating
_____ Urination when cough or sneeze
_____ Strong smelling urine
_____ Mild back pain
_____ Interrupted urine stream
_____ Tingling in joints
_____ Joint and muscle pain/cramping
_____ Can't hold urine
_____ Dark circles under eyes
_____ Frequent urge to urinate but passes only small amounts

Section N

Medications you are currently taking: _____

How often do you take (or have taken) antibiotics? _____ Reaction to vaccinations? _____ Y/N

How many silver amalgams do you have in your mouth? _____ Root canals? _____ Crowns/bridges? _____

Were your wisdom teeth impacted _____Y/N Other Dental problems _____ Y/N Allergies _____Y/N

Are you experiencing bone loss or osteoporosis? _____ Y/N Do you smoke? _____ Y/N

Diagnosed for parasites? _____ Y/N Diagnosed or history of Candida? _____ Y/N

Drink 6-8 glasses of water daily? _____ Y/N Hormone replacement medications? _____ Y/N

Important: Please list below you main health complaints <u>in order of importance</u>

1. _____
_____
2. _____
_____
3. _____
_____
4. _____
_____

- You are invited to discuss any questions regarding services. The best health services are based on a friendly, mutual understanding between provider and client.
- Our policy requires payment in full for all services rendered at the time visit, unless other arrangements have been made.
- If you are going to be more than 10 minutes late for an appointment, it will be necessary to reschedule. You agree to pay a $35 charge for a first missed visit. After second or more missed appointments, you agree to pay the full appointment charge of $60.
- I authorize Dr. Reeves to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health status.

Signature: _____ **Date:** _____ / _____ / _____

Done filling out the form?

Take these next steps before coming in for your appointment:

Click the button below to email this document to us.

SUBMIT

We will evaluate your form and be ready for you when you come in for your appointment.

Excelsior HEALTH CENTER

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