CAP WELLNESS CENTER

New Patient Information Form

Date: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone #: _____

Cell Phone #:_____

E-Mail: _____

Birthdate: _____ Age: _____ □ Male □ Female

Marital Status: □ Single □ Married Partner/Spouse's Name: _____

# of Children: _____ Names & Ages: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Contact's Phone #: _____

Relationship to Emergency Contact: _____

Who may we thank for referring you to our office? _____

Have you received acupuncture before? □ Yes □ No

Have you received light-force chiropractic care before? □ Yes □ No

Have you received massage before? □ Yes □ No Done Yoga? □ Yes □ No

Are you seeing any other physician/practitioner regularly right now? □ Yes □ No

If so, for what condition? _____

Name of Physician: _____

Specialty: _____ Contact info: _____

Current Concerns

What brings you to our Wellness Center today? How can we help you?

_____

How long have you had this condition? _____

Do you have a medical diagnosis for this condition? _____

Was it a: □ sudden or □ gradual onset? Is it: □ getting better □ getting worse □ the same

Symptoms are worse with: _____

Symptoms are better with: _____

On a scale of 1-10, how severe is the pain or condition? _____

Describe how this condition affects your overall quality of life, work, family life, emotions?

_____

_____

What other treatments have you tried?_____

Were/are they helpful? _____

Are you taking any medications? □ Yes □ No If so, please list:

_____

_____

Are you taking any vitamins, supplements, herbs or minerals? □ Yes □ No If so, please list:

_____

_____

Do you have any allergies? □ Yes □ No If so, please list:

_____

Have you had any major accidents, falls or other physical traumas? □ Yes □ No

Please list:_____

_____

Have you had any surgeries or hospitalizations? □ Yes □ No

Please list:_____

_____

If female, are you currently pregnant? □ Yes □ No #weeks:

Or if female, are you currently *trying* to get pregnant? □ Yes □ No

Current Health & Lifestyle Habits

Please check all that apply and describe how much/how often.

____Do you smoke? _____

____Drink caffeine? _____

____Drink alcohol? _____

____Take recreational drugs? _____

____Eat sugar? _____

____Drink water? _____

How would you describe your typical diet and the quality of it:

_____

What foods do your crave?_____

Do you exercise regularly? □ Yes □ No How many times per week? _____

What do you like to do for exercise? _____

Describe the quality of your sleep: _____

How many hours a night do you sleep? _____

Do you have difficulty falling asleep? □ Yes □ No How long does it take? _____

Do you have difficulty staying asleep? □ Yes □ No How many times do you wake up? _____

On a scale of 1-10, what is your general stress level right now? _____

Describe the major stresses in your life…

At home: _____

At work: _____

In relationship: _____

Other: _____

What do you do to relax? _____

What do you do for fun/pleasure? _____

Symptoms

Check the box for each symptom you currently experience (or had a significant problem with in the past).

LIVER/GALLBLADDER

___ Irritability
___ Depression
___ Headaches/migraines
___ Visual problems
___ Red eyes
___ Dry/itch eyes
___ Spots in front of eyes
___ Feeling lump in throat
___ Teeth Clenching
___ Muscle cramping
___ Muscle twitching
___ Joints feel tight/stiff
___ Often up past 1A.M
___ Cold hands/feet
___ Soft/brittle nails
___ Craving/avoiding sour foods

HEART/SMALL INTESTINE

___ Heart palpitations
___ Chest pain
___ Dizziness
___ Insomnia
___ Easily startled
___ Restlessness/agitation
___ Anxiety
___ Breathlessness
___ Vivid dreams
___ Dreams are bothersome
___ Lack of joy in life
___ Laughing for no reason
___ Craving/avoiding bitter foods

KIDNEY/BLADDER

___ Urinary problems
___ Frequent urination
___ Incontinence
___ Bed wetting
___ Weak/pain in lower back
___ Aching bones
___ Feel cold easily
___ Low sexual energy
___ Excess sexual desire
___ Little desire to drink
___ Fearful/frightened easily
___ Poor memory
___ Loss of hair
___ Hearing problems
___ Ringing in ears
___ Craving/avoiding salty foods

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LUNG/LARGE INTESTINE

___ Dry cough
___ Cough with sputum
___ Nasal discharge
___ Poor sense of smell
___ Nose bleeds
___ Itchy, red or painful throat
___ Dry mouth
___ Skin rashes
___ Oily skin
___ Itchy skin
___ Grief, sadness
___ Shortness of breath
___ Allergies
___ Frequent colds/flu

___ Low physical stamina
___ Mild fever often
___ Hot palms of hands/feet
___ Craving/avoiding spicy foods

SPLEEN/STOMACH

___ Heaviness in body
___ Fatigue
___ Hard to get up in morning
___ Edema (swelling)
___ Muscles feel tired often
___ Easy bruising & bleeding
___ Bad breath
___ Low appetite
___ Snacking
___ Tendency towards hypoglycemia
___ Difficulty digesting oily foods
___ Nausea
___ Vomiting
___ Gas/belching
___ Bloating
___ Hemorrhoids
___ Constipation
___ Diarrhea
___ Abdominal pain
___ Indigestion/heartburn
___ Over-thinking
___ Tendency to obsess
___ Craving/avoiding sweets

Females only: Age started menstruation: _____ Age stopped: _____

Form of Birth Control: _____

Last Period:_____ Last PAP: _____ Are you Pregnant? □ Yes □ No #wks:

Do you experience: □ Menstrual Pain □ Low backache □ Water retention □ Clotting

□ Mood changes □ Hot flashes □ Irregular □ Painful breast

□ Heavy Bleeding □ Vaginal discharge □ Vaginal dryness □ Other: _____

# of Pregnancies: _____ # of Vaginal deliveries: _____ # of Caesarians: _____

# of Miscarriages: _____ # of Abortions: _____

If you could have it *any* way you wanted it, what would your health and wellness be like? What would you like to do (that you can't do now)? How would you like to feel?

_____

_____

What is one thing you could **start** doing that would allow you to have it this way?

_____

What is one thing you should **stop** doing that would allow you to have it this way?

_____

What are your Health & Wellness Goals for yourself **right now** that you would like our help with? _____

_____

With regard to what brought you into our office, are you interested in:

□ Temporary relief or □ Permanent solutions

If Lifestyle recommendations are appropriate, are you interested in learning more about:

□ Proper Exercise □ Proper Nutrition □ How to better handle Lifestyle stress

Are there any other health concerns or anything else you'd like us to know about you?

_____

_____

_____

Thank you for filling out this form.

Congratulations on taking this important step towards creating more health, more balance & more happiness for yourself!

I consent to a complete professional health examination and to any further examination procedures that the doctor/practitioner deems necessary. In the interest of integrated patient care, I give permission to providers at CAP Wellness Center and those at CAP Women's health to communicate with each other regarding my treatment and care.

Signature_____ Date: _____