New Patient Questionnaire (WL)

Today's Date: _____

First Name & Middle Initial: _____ **Last Name:** _____ **Email:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____ **Date of Birth:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Gender:** ☐ **Male** ☐ **Female**

Military Veteran: YES NO Marital Status: _____

Emergency Contact Name & Phone #:_____

☐ I wish to opt out of any clinic updates via email.
This includes: newsletters, deals, coupons and promotions.

Who encouraged you to lose weight?: _____

How important to you is it to lose weight?: _____

What important reason, special occasion, or goal date do you have to lose weight?: _____

How many pounds would you like to lose?: _____ How fast do you want lose the weight?: _____

Would you commit to one visit a week?: ☐ Yes ☐ No

Have you ever attended any other weight reduction centers, if so, which ones?: _____

What kinds of diets have you tried on your own?: _____

What is the longest you have been able to stick with a diet?: _____

Does your family support your weight loss efforts?: ☐ Yes ☐ No

Have you been advised by your family physician to lose weight?: ☐ Yes ☐ No

Do you eat because of emotions?: ☐ Yes ☐ No

If you answered yes, please explain: _____

What is most important to you in deciding to use our services? (Please check all that apply):

- ☐ Effectiveness "My results are my top priority."
- ☐ Time "I want results quickly."
- ☐ Service "I need extra support along the way."
- ☐ Ease "I have a difficult time losing weight."

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

_____ _____

Signature: **Date:**

On average, which of the following reflects your daily eating habits? (Please check all that apply):

- ☐ 3 meals with healthy snacks
- ☐ 3 meals
- ☐ 2 meals or less
- ☐ Skip breakfast or other meals
- ☐ Generally eat on the run
- ☐ No regular eating pattern
- ☐ Often crave sweets/carbs
- ☐ Graze; small, frequent meals (How many per day? _____)

Current level of exercise (Please check one that applies):

- ☐ None
- ☐ Light exercise (1-3 times per week, easy pace, stretching, walking, etc.)
- ☐ Moderate exercise (2-3 times per week, moderate pace, some weights, etc.)
- ☐ Heavy exercise: (3-4 times per week, vigorous pace, weights, fast running, etc.)

Health Information

Past or Present Health Conditions (Please check all that apply):

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Strokes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hormone Imbalance
- ☐ Hormonal Cancer
- ☐ Thyroid Imbalance
- ☐ Anorexia
- ☐ Bulimia
- ☐ Drug Addiction
- ☐ Currently pregnant or nursing
- ☐ Allergic to sulfur, food or medication
- ☐ Vegetarian

If you checked any of the above, please explain: _____

_____

Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment?: ☐ Yes ☐ No

If you answered yes, please explain: _____

_____

Please list all medications you are currently taking, including doses and reasons for taking

Medication:	Dose:	How often:	Reason:	Prescribing M.D.

Symptom Survey

Please complete the following survey using the key below

☑ ☐ ☐ ☐ = No symptoms (0 points)
☐ ☑ ☐ ☐ = Mild symptoms (1 point)
☐ ☐ ☑ ☐ = Moderate symptoms (2 points)
☐ ☐ ☐ ☑ = Severe symptoms (3 points)

Weight:

☐ ☐ ☐ ☐ Inability to lose weight
☐ ☐ ☐ ☐ Food cravings
☐ ☐ ☐ ☐ Binge eating
☐ ☐ ☐ ☐ Nausea or vomiting
☐ ☐ ☐ ☐ Water retention

Hormone:

☐ ☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ ☐ Weight gain
☐ ☐ ☐ ☐ Hair loss
☐ ☐ ☐ ☐ Depression/ anxiety
☐ ☐ ☐ ☐ Mental fuzziness
☐ ☐ ☐ ☐ Memory problems
☐ ☐ ☐ ☐ Fatigue
☐ ☐ ☐ ☐ Decreased libido
☐ ☐ ☐ ☐ Aggression
☐ ☐ ☐ ☐ Hot flashes and/or night sweats

Head and Ears:

☐ ☐ ☐ ☐ Migraines
☐ ☐ ☐ ☐ Headaches

Emotional and Mental:

☐ ☐ ☐ ☐ Depression
☐ ☐ ☐ ☐ Anxiety
☐ ☐ ☐ ☐ Mood swings
☐ ☐ ☐ ☐ Irritability
☐ ☐ ☐ ☐ Poor concentration

Skin Conditions:

☐ ☐ ☐ ☐ Acne /acne scars
☐ ☐ ☐ ☐ Sagging skin
☐ ☐ ☐ ☐ Fine lines and wrinkles
☐ ☐ ☐ ☐ Loss of volume
☐ ☐ ☐ ☐ Enlarged pores
☐ ☐ ☐ ☐ Lip lines

Hair Conditions:

☐ ☐ ☐ ☐ Hair loss
☐ ☐ ☐ ☐ Thinning hair
☐ ☐ ☐ ☐ Receding hair

Muscle & Joint:

☐ ☐ ☐ ☐ Arthritis
☐ ☐ ☐ ☐ Foot trouble
☐ ☐ ☐ ☐ Low back pain
☐ ☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ ☐ Pain between shoulders
☐ ☐ ☐ ☐ Headaches
Pain or numbness in:
☐ ☐ ☐ ☐ Shoulders
☐ ☐ ☐ ☐ Arms
☐ ☐ ☐ ☐ Elbows
☐ ☐ ☐ ☐ Hips
☐ ☐ ☐ ☐ Legs
☐ ☐ ☐ ☐ Knees
☐ ☐ ☐ ☐ Sciatica

Energy:

☐ ☐ ☐ ☐ Fatigue
☐ ☐ ☐ ☐ Lethargy
☐ ☐ ☐ ☐ Restlessness
☐ ☐ ☐ ☐ Insomnia
☐ ☐ ☐ ☐ Hyperactivity

Other Symptoms:

☐ ☐ ☐ ☐ Irregular heartbeat
☐ ☐ ☐ ☐ Chest pains
☐ ☐ ☐ ☐ Muscle aches

Please list any symptoms you experience that were not previously mentioned: _____

Initial Confidential Patient Case History

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O F C

GENERAL

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fever
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLE & JOINT

☐ ☐ ☐ Bursitis
☐ ☐ ☐ Hernia
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Painful tail bone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen joints

CARDIO-VASCULAR

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ Swelling of ankles

O F C

GASTRO-INTESTINAL

☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Distension of abdomen
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Gall bladder trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting of blood

RESPIRATORY

☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficult breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Wheezing

SKIN

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins

FOR WOMEN ONLY

☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excessive menstrual flow
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge
☐ Yes ☐ No Are you pregnant?

O F C

EYES, EARS, NOSE &THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental Decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noises
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Tonsillitis

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Inability to control kidneys
☐ ☐ ☐ Kidney infection or stones
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Anemia	☐ Diphtheria	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Appendicitis	☐ Eczema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Arteriosclerosis	☐ Emphysema	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Candidacies	☐ Epilepsy	☐ Measles	☐ Psychiatric Disorder	☐ Whooping cough
☐ Chorea	☐ Fever Blisters	☐ Miscarriage	☐ Rheumatic Fever	
☐ Cold sores	☐ Goiter	☐ Multiple sclerosis	☐ Scarlet fever	
☐ Depression	☐ Gout	☐ Mumps	☐ Tuberculosis	

If you answered YES to any of the above conditions, please explain: _____
_____
_____
_____

What is your major complaint?
_____
_____
_____
_____

List surgical operation and years:
_____
_____
_____
_____

FAMILY HISTORY: Please specify members of your family including extended family who have these illnesses.

CANCER: _____
HYPOTHYROIDISM: _____
HIGH BLOOD PRESSURE: _____
HYPOGLYCEMIA: _____
OBESITY: _____
HEART DISEASE: _____

Patient's Release of the Provider of Service and the Clinic

The undersigned hereby represents that I have disclosed all pertinent information regarding my health profile to the provider of service during my examination. Patient further represents and guarantees that Patient has disclosed all/current medications (whether prescription or non-prescription) to this provider of service during my examination. I have also disclosed where I obtain my medications, and if the medications are by prescription, the name of the prescribing doctor.

I understand that this provider of services will make a determination based on full disclosure by the patient.

I acknowledge that this provider of services reserves the right to limit any patient's medications to an appropriate amount based on information disclosed by the patient during the examination.

Should the provider obtain information that in any way suggests false representation were made to this provider by the patient, Patient without reservation waives any and all rights to any claim of any type or nature whatsoever, including but not limited to monetary damages, which Patient now has or in the future may accrue against the provider of service and this clinic.

As a patient I also understand that if I go to another provider of service during the time frame of treatment at this clinic, I am to notify this clinic and its representatives immediately of any other medications I might be receiving and that said notification must be given in writing to this clinic and or its representative.

Please be advised that Northwoods Family Chiropractic requires that all patients have a yearly diet panel drawn to provide us with a thorough perspective of our patient's general health. We also require all new patients and returning patients have a diet panel drawn within the first two weeks of their initial visit. However, extenuating circumstances will be taken into consideration. This is to protect our patients and allow us to provide safe, effective assistance for weight loss and lifestyle change.

As the patient, I have read and understand this release. I also understand that this release constitutes a legal and binding document. I understand, specifically, that there is no guarantee regarding success of the services provided.

Patient signature: _____ Date: _____

Patient Printed name: _____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause

any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The treating provider, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through healthcare procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the provider., This office does not perform breast, pelvic, prostate, rectal or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other that those addressed in your care plan.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicine, or allergies.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices o Northwoods Family Chiropractic.

(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of Northwoods Family Chiropractic to leave reminder messages on voicemail/answering machines or with another person in the household. I may make a request of an alternative means of communication (within reason) in writing.

May we discuss your medical condition with any member of your family?	YES	NO
May we discuss your billing information with any member of your family?	YES	NO

If YES, please name the members allowed:

X_____ _____

Signature of Patient/Guardian Date

X_____ _____

Witness (Office Staff) Date