



New Patient Welcome Form

Patient Information

Date _____ Date of Birth _____

Patient Name _____
First M Last

What do you prefer to be called? _____

Address _____

City _____ State _____ Zip _____

Patient SSN# _____ Do you? Rent Own

Sex Male Female Language (If other than English) _____

Ethnicity (Mark one) Hispanic or Latino Not Hispanic or Latino

Race (Mark one or more) American Indian or Alaska Native Asian White
 Black or African American Native Hawaiian or Other Pacific Islander

Cell Phone _____ Cell Phone Carrier _____

Home Phone _____ E-mail _____

Occupation _____

Employer/ School _____

Employer/ School Address _____

City _____ State _____ Zip _____

Employer/ School Phone _____

If Minor, Parent/Legal Guardian's Name _____
 Married Single Widowed Divorced Separated

Spouse's Name _____

Spouse's Cell Phone _____

Spouse's Employer _____

How did you hear about us? _____

Health Insurance

Do you have a Flex Spending (FSA) or Health Savings (HSA) Account? Y N

Insurance Company _____

Policy # _____ Group # _____

Relationship to the patient Self Spouse Child Other

* If you selected "self" please stop here and proceed to the next section.

Policy Holder _____
First M Last

Policy Holder's Date of Birth _____ Sex Male Female

Policy Holder's Address, City, State, Zip _____

Policy Holder's Employer _____

Employer City _____ State _____ Zip _____

Employer Phone _____

Secondary Health Insurance

Insurance Company _____

Policy # _____ Group # _____

Relationship to the patient Self Spouse Child Other

* If you selected "self" please stop here and proceed to the next section.

Policy Holder _____
First M Last

Policy Holder's Date of Birth _____ Sex Male Female

Policy Holder's Address, City, State, Zip _____

Policy Holder's Employer _____

Employer City _____ State _____ Zip _____

Employer Phone _____

Emergency Contact This must be someone NOT living in your household.

Name: _____ Relationship: _____ Cell Phone: _____ Home Phone: _____

Address: _____ City, State, Zip: _____

Designation of Personal Representative

Name: _____ Relationship: _____ Cell Phone: _____ Home Phone: _____

Address: _____ City, State, Zip: _____

I hereby designate the above named individual as my personal representative who may act on my behalf for the purpose of: Consenting to use and disclosure of my health information, authorizing use and disclosure of my health information, and receiving information that otherwise would be sent me. If I am incapacitated, my personal representative may also sign any form (such as authorization, revocation of authorization, request for access to information and/or billing inquiries), the uses of which are described in privacy policies and procedures. I understand that a person who is identified in my medical record as having medical power of attorney or other legal authority to act on my behalf is additionally recognized as my personal representative. I understand that I have the right to revoke this authorization at any time. Revoking this authorization must be made in writing, signed, and dated.

Authorization and Medical Release

I affirm that the above information is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize the doctor to treat my condition as he deems appropriate and to grant full disclosure for all previous or concurrent care. I agree to grant full indemnity to Alternative Wellness & Chiropractic Center and it's physicians for complications related to all pre-existing conditions medically diagnosed or otherwise not disclosed.

Patient or Guardian Signature _____ Date _____

Print Guardian Name _____ Relationship to Patient _____



Name: _____

I. HEALTH HISTORY

Do you smoke?* Y N Social Quit

Current Medication:* _____

I will provide a list of my medications.

Allergies:* _____

Medication Intolerance:* _____

Personal Disease/Illness

List any past history of disease/illness Month/Year

Family Disease/Illness

List any family history of disease/illness Relationship Month/Year

Hospitalizations/Surgeries/Injuries

List Past Hospitalizations/Surgeries/Injuries Month/Year

Primary Physician(s) _____

Date of Last Exam _____

Date of Last X-ray _____

II. REVIEW OF SYSTEMS

Have you at any time had: (Check all that apply)

Head and Neck

- Decreased hearing
- Ringing in ears
- Frequent ear infections
- Dizzy spells
- Failing vision
- Double or blurred vision
- Eye pain
- Repeated eye infections
- Recurrent nose bleeds
- Sinus/throat infections

Cardiovascular

- High blood pressure*
- Pain (chest, arms or legs)
- Palpitations
- Irregular heart beat
- Swollen ankles
- Fainting spells

Digestive

- Difficulty swallowing
- Indigestion or heartburn
- Nausea/vomiting
- Diarrhea
- Constipation
- Blood in bowel movement
- Black bowel movement

Neurological/Phyc

- Numbness/Tingling
- Headache
- Nervousness
- Memory Loss
- Moodiness
- Difficulty falling asleep
- Difficulty staying awake
- Increased irritability
- Depression/Anxiety

Endocrine

- Chronic fatigue
- Weight gain/Weight Loss (recent)
- Bruise easily
- Cold extremities
- Tremors (shaking of hands)
- Convulsions
- Muscle weakness

Respiratory

- Hoarseness
- Persistent cough
- Blood in spit
- Shortness of breath

Skin

- Rash
- Hives
- Moles (cancerous)

Genitourinary

- Diabetes*
- Painful urination
- Blood in urine
- Frequent urination
- Frequent night time urination
- Loss of control of urine
- Sexual dysfunction

Musculoskeletal

- Neck pain
- Joint swelling
- Mid back pain
- Low back pain
- Foot pain
- Stiff joints

Other Symptoms

Women Only

Are you pregnant? Y N If Yes, Last Menstrual Period _____ Due Date _____

Are you nursing? Y N Are you planning a pregnancy? Y N

- Breast tenderness associated with cycle
- Endometriosis
- Night sweats (in menopausal females)
- Breast fibroids, benign masses
- Vaginal discharge, dryness, itchiness
- Urinary Tract, bladder, kidney infections
- Menstruation Problems
- Thyroid Problems _____
- Other _____
- Uterine fibroids
- Hot flashes

Men Only Do you experience any of the following? (Check all that apply)

- Prostate problems
- Pain on inside of thighs, legs or heels
- Difficulty with urination, dribbling
- Feeling of incomplete bowel evacuation
- Difficult to start and stop urine stream
- Decreased sexual function
- Pain or burning with urination
- Other _____
- Interruption of stream during urination

III. REASONS FOR SEEKING CARE

Present Complaints

1. _____ **How long has this been an issue?** _____

Is it: Dull Sharp Ache Numb/Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in morning Worse in evening Pain radiates to _____

2. _____ **How long has this been an issue?** _____

Is it: Dull Sharp Ache Numb/Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in morning Worse in evening Pain radiates to _____

3. _____ **How long has this been an issue?** _____

Is it: Dull Sharp Ache Numb/Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in morning Worse in evening Pain radiates to _____

4. What makes it better? _____

5. What makes it worse? _____

6. What Doctor's have you seen for this? _____

7. Type of treatment: _____

8. Results: _____

Rate your pain 0 to 10, ten being the worst

Mark ALL areas of pain on figures below

Neck Pain

0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain

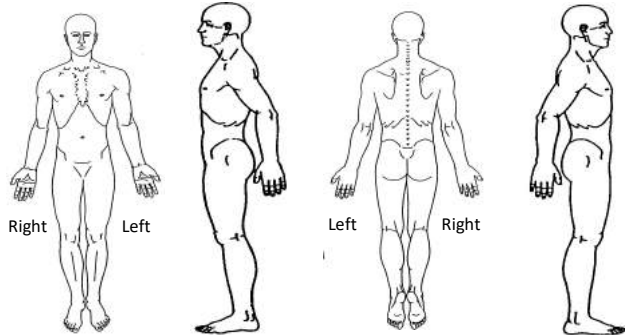
0 1 2 3 4 5 6 7 8 9 10

Low Back, Hip Pain

0 1 2 3 4 5 6 7 8 9 10

Other Pain _____

0 1 2 3 4 5 6 7 8 9 10



IV. CERTIFICATION

I certify that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and to the best of my ability. I will not hold my chiropractor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature _____ Date _____

(Office Use Only)

The above health history questionnaire was reviewed by _____ (Physician) Date _____

Neck Pain Index

Please read: This questionnaire is designed to enable us to understand how much your **neck pain** has affected your ability to manage everyday activities. Please answer each section by checking the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just check the one choice which closely describes your problem right now.**

Section 1 PAIN INTENSITY

- I have no pain at the moment.
- The pain is mild at the moment.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain is severe but comes and goes.
- The pain is severe and does not vary much.

Section 2 PERSONAL CARE (washing, dressing, etc.)

- I can look after myself without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but I manage most of my personal care.
- I need some help in most aspects of self-care.
- I do not get dressed, I wash with difficulty and I stay in bed.

Section 3 LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights, if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

Section 4 READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

Section 5 HEADACHE

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Section 6 CONCENTRATION

- I can concentrate fully, when I want with no difficulty.
- I can concentrate fully, when I want with slight difficulty.
- I have a fair degree of difficulty concentrating when I want to.
- I have a lot of difficulty concentrating when I want to.
- I have a great deal of difficulty concentrating when I want to.
- I cannot concentrate at all.

Section 7 WORK

- I can do as much work as I want to.
- I can only do my usual work but no more.
- I can do most of my usual work but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

Section 8 DRIVING

- I can drive my car without neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I cannot drive at all.

Section 9 SLEEPING

- I have no trouble sleeping.
- My sleeping is slightly disturbed. (less than 1 hour sleepless)
- My sleep is mildly disturbed. (1-2 hours sleepless)
- My sleep is moderately disturbed. (2-3 hours sleepless)
- My sleep is greatly disturbed. (3-5 hours sleepless)
- My sleep is completely disturbed. (5-7 hours sleepless)

Section 10 RECREATION

- I am able to engage in all recreational activities with no pain in my neck at all.
- I am able to engage in all recreational activities with some pain in my neck.
- I am able to engage in most but not all recreational activities because of my neck pain.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck
- I cannot do any recreational activities at all.

Signature _____

Date _____ File # _____ Disability Index Score: _____ Improvement _____ %
Oswestry Disability Index

Low Back Disability Index

Please read: This questionnaire is designed to enable us to understand how much your **low back pain** has affected your ability to manage everyday activities. Please answer each section by checking the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just check the one choice which closely describes your problem *right now***.

Section 1 Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

Section 2 Personal Care (washing, dressing, ect.)

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any of my washing and dressing without help.

Section 3 Lifting

- I can lift weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

Section 4 Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I can not walk more than one mile without increasing pain.
- I can not walk more than ½ mile without increasing pain.
- I can not walk more than ¼ mile without increasing pain.
- I can not walk at all with out increasing pain.

Section 5 Sitting

- I can sit in a chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain.

Section 6 Standing

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I can not stand for longer than one hour without increasing pain.
- I can not stand longer than ½ hour without increasing pain.
- I can not stand longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

Section 7 Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of my pain, my normal nights sleep is reduced by less than ¼.
- Because of my pain, my normal nights sleep is reduced by less than ½.
- Because of my pain, my normal nights sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

Section 8 Social Life

- My social life is normal and gives my no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, ect.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

Section 9 Traveling

- I get no pain while traveling.
- I get some pain while traveling but none of my usual forms of travel make it any worse.
- I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternate forms of travel.
- Pain restricts all forms of travel.
- Pain prevents me from all forms of travel except that dome lying down.

Section 10 Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall it is definitely getting better.
- My pain seems to be getting better but improvement is slow.
- My pain is neither getting better nor getting worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Signature _____

Date _____ File # _____ Disability Index Score: _____ Improvement _____ %
Revised Oswestery Disability