Elite Wellness & Chiropractic

Elite Wellness & Chiropractic is a family wellness center. Our mission is to create a community of families and individuals that is focused on living healthy, prosperous, and abundant lives. It is our pleasure to welcome you to our family of happy and healthy practice members. Please help us serve you in the best way possible by completely filling out this application for care. Also, we would like to recognize the person responsible for recommending our practice, please let us know who we can thank.

Person who referred you: ______________________________

Today's Date:_______-______-______

Name:______________________________ Name you go by:______________________________

Birth Date:______-______-______ Age: ___________ ☐ Male ☐ Female

Address:______________________________

City:______________________________ State: ______________ Zip:______________

E-mail Address: ______________________________

Home Phone:______________________________ Mobile Phone:______________________________

Do you have Insurance: ☐ Yes ☐ No Name of Insured:______________________ Insured Date of Birth___/___/____

Employer:______________________________ Occupation: ______________________________

Spouse's Name ______________________________ No. of Children:_________ Ages:______________________

______________________________ Name & Number of Emergency Contact:______________________

______________________________ Relationship:______________________________

Are you pregnant? ☐ Yes ☐ No ☐ Trying ☐ N/A Date of your last menstruation:______________________

Are you breastfeeding? ☐ Yes ☐ No

If you would like to receive text/email reminders for your appointment(s), please list your mobile phone number with your service provider, and/ or your email:

______________________ ______________________

Mobile Phone Service Provider

At Elite Wellness & Chiropractic, we are dedicated to achieving the goal of total lasting health for all of our patients. To better understand your individual health objectives, please check all that apply that are closest to your personal health goal(s):

☐ **Restore health** ☐ **Increase wellness** ☐ **Improved performance** ☐ **Symptom or temporary relief**

What are your three Main Health Goals? Please rank them in order of priority.

1. ______________________________
2. ______________________________
3. ______________________________

What are your current expectations for seeking our services?

____

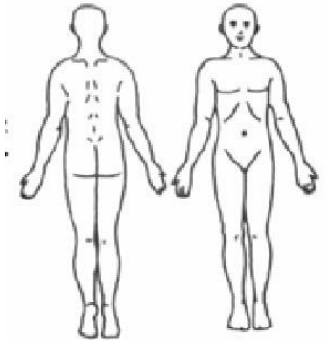
How important is your health to you (0 not at all, 10 utmost importance)? **0 1 2 3 4 5 6 7 8 9 10**

If we discover a health problem, how important to you is correcting it? **0 1 2 3 4 5 6 7 8 9 10**

Please identify the condition(s) that brought you into this office:

Mark the areas on the diagram with the following letters to describe your symptoms:
D-dull, S-Sharp, A-aching, B-burning, T-tingling, N-numbness, C-cramping, W-weakness

1 **Complaint:** ___

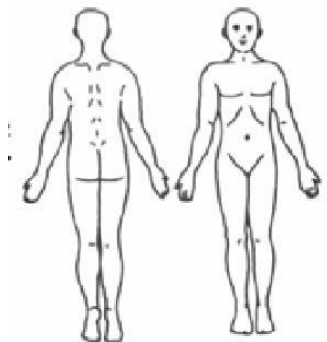


When did this begin?___ How?___
Have you had this problem in the past? No___Yes___ If yes, how many times? ___
Does the pain travel or radiate anywhere? No___ Yes___ If yes, where? ___
What makes it worse/aggravates it?___
What have you done that helps it feel better?___
On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain, rate your complaint:

At its worst **0 1 2 3 4 5 6 7 8 9 10** *At its best* **0 1 2 3 4 5 6 7 8 9 10**
Average **0 1 2 3 4 5 6 7 8 9 10** *In the past* **0 1 2 3 4 5 6 7 8 9 10**

When is this problem at its worst?___AM___Mid-day___PM___Late PM
How long does it last?___constant___on & off throughout day___comes & goes throughout week
Have you been treated for this condition in the past? No___Yes___If yes, when:___
By whom?___For how long? ___
What were the results? ___
How does this condition affect your activity level? ___

2 **Complaint:** ___



When?___How? ___
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Subluxations are a condition of the spine that Chiropractors are trained to detect. Research is now showing that dysfunction within the body can be the result of these subluxations. Often other symptoms are apparent for years before spinal pain is noticed. It is for this reason we ask a wide variety of questions regarding your health. On a daily basis we experience physical, dietary, and environmental stressors that lead to subluxations. Help us identify yours.

Previous Chiropractor_________________________ Date of last visit & reason_________________________
Were spinal maintenance programs given to you to maximize the stability of your spine? ☐ No ☐ Yes

Are other family members under chiropractic care? ☐ No ☐ Yes who? _________________________
Name of Medical Doctor _________________ Date of last visit and reason _________________
Are you satisfied with the care you received there? _________________________
May we update your medical doctor with your progress in our office? ☐ No ☐ Yes
Who was the last Doctor who created a health development plan for you? _________________________
Did you follow the Doctors recommendation? ☐ No ☐ Yes, for how long? _________________________
What were the results? _________________________
What other wellness professionals are currently part of your health care team?

☐ Massage Therapist ☐ Acupuncturist ☐ Naturopath ☐ Homeopath ☐ Other_________________

On a scale of **1-5**, **1** being the worst and **5** being the best:	Very Challenged	Challenged	Transition	Good	Very Good
How do you rate your health currently?	1	2	3	4	5
Where would you like your health to be?	1	2	3	4	5
How healthy do you consider your family?	1	2	3	4	5
How committed are you to achieving your health goals?	1	2	3	4	5

OTHER SYMPTOMS PAST OR PRESENT check all that apply

Many patients are surprised to find out that chiropractic care can help many of the below conditions, feel free to ask how your condition may also be affecting the above complaints.

○ Dizziness	○ Blood pressure	○ Migraines	○ Acid Reflux	○ Anemia	○ Hyperactivity/Behavioral
○ Ruptures	○ Neck Problems	○ Ear aches	○ Sore throats	○ Hernias	○ Numbness of arms or hands
○ Diabetes	○ Poor Appetite	○ Irritability	○ Leg problems	○ Urinary	○ Numbness of legs or feet
○ Breathing	○ Growing pains	○ Headaches	○ Loss of smell	○ Arthritis	○ Arm problem
○ Fainting	○ Stomach aches	○ Convulsions	○ Bed Wetting	○ Asthma	○ Blood disorders
○ Insomnia	○ Heart Problems	○ Bronchitis	○ Muscle jerking	○ Diarrhea	○ Coordination
○ Colds/Flu	○ Loss of balance	○ Osteoporosis	○ Hypertension	○ Cancer	○ Walking problems
○ Epilepsy	○ Broken bones	○ Joint Pain	○ Bone fractures	○ Fatigue	○ Sinus problems
○ Backaches	○ Muscle Cramps	○ Depression	○ Constipation	○ Allergies	○ Digestive problems

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Environmental Stress Check all that apply

Prescription and non-prescription medicines you are taking: ○ Blood Pressure ○ Anti-Depressant ○ Birth Control

○ Tylenol ○ Asthma ○ Cold/Allergy ○ Blood Thinners ○ Advil/Ibuprofen

○ Anxiety ○ Hormones ○ Sleep Aids ○ Attention Aids ○ MuscleRelaxers

○ Other ____________________

Do you take any vitamins or Herbs? ☐No ☐Yes, are they: ☐Synthetic ☐Food Based

What supplements are you currently taking? 1)__________ 2) __________

3) __________ 4) __________ 5) __________

Do you currently smoke? ☐No ☐Yes, for how long?__________ How much?__________

Have you ever smoked? ☐No ☐Yes, for how long?__________ How much?__________

Do you use any other types of tobacco products? ☐No ☐Yes,

What types of products?__________For how long?__________How much?__________

Do you consume alcohol? ☐No ☐Yes, if so how much? __________

Do you currently or have you ever used recreational drugs? ☐No ☐Yes, if so what types? __________

Emotional Stress

What do you do for stress relief?__________

Do you exercise? ☐No ☐Yes, how often?__________ What type of exercise?__________

Do you get adequate amounts of sleep? ☐No ☐Yes

How many hours of sleep do you get on average?__________

Do you sleep through the night without waking up? ☐No ☐Yes

How stressful do you rate:

Personal Relationships	No Stress	1	2	3	4	5	6	7	8	9	10	Extreme Stress
Occupational	No Stress	1	2	3	4	5	6	7	8	9	10	Extreme Stress
Mindset	No Stress	1	2	3	4	5	6	7	8	9	10	Extreme Stress
Finances	No Stress	1	2	3	4	5	6	7	8	9	10	Extreme Stress

Are there any other health habits that the doctor needs to be aware of? __________

____

Nutritional Stress

How many of the following products do you use a week?

	0	1	2	3	4	5+
Diet beverages/Soda?	0	1	2	3	4	5+
Zero calorie/sugar free beverages?	0	1	2	3	4	5+
Artificial Sweeteners?	0	1	2	3	4	5+
Coffee?	0	1	2	3	4	5+
Energy products?	0	1	2	3	4	5+

Do you get tired/ sleepy after a meal? ☐ Yes ☐ No

Do you get sensitive or angry if a meal is missed? ☐ Yes ☐ No

Circle the meals you eat: **Breakfast** **Lunch** **Dinner**

Are you a vegetarian? ☐ Yes ☐ No

Do you use artificial sweeteners? ☐ Yes ☐ No

Where do you get your groceries? (name of store) ____________________

How much water do you drink per day? __________ Is it bottled water? ☐ Yes ☐ No

Physical Stress

The vast majority of our patients have experienced dozens of falls or impacts (auto/work/sports/hobbies) that could either begin or exacerbate subluxations. Help us discover a few of yours.

Current Weight__________ Goal Weight__________ Height__________

Which sports have you participated in? Check all that apply. ○ Football ○ Gymnastics ○ Wrestling ○ Cheerleading ○ Basketball ○ Martial Arts ○ Baseball ○ Horseback ○ Soccer ○ Other:____________________

Have you ever…? ○ Sports Injury ○ Stress or strain while working ○ Perform repetitive tasks (typing/lifting) ○ Slipped/Fell on ground ○ Fallen down the stairs ○ Broken a bone, if so which?__________ ○ Sit more than 4 hours per date ○ Drive more than 2 hours per day

Have you ever been knocked unconscious or diagnosed with a concussion? ○ No ○ Yes, if so how many?__________

List any surgical operations and date performed. ____________________

____

List any auto accidents and date of. ____________________

____

Any other bodily trauma? ____________________

____