GAULT WELLNESS CENTER

Name _____ **Weight** _____ **lb**
Date _____ **Chiro Video @ ROF** _____

CONFIDENTIAL PATIENT DATA 2

If you need assistance completing this form, please ask the receptionist

PATIENT INFORMATION

Name: _____
Address: _____
_____
City: _____
State: _____ Zip: _____
Employer: _____
Occupation: _____
Date of Birth: _____
Marital Status: □ Single □ Married
Person to Contact in case of emergency: _____
Your relationship to them □ Spouse □ Family Member □ Other _____
Who can we thank for referring you to our office?
Your relationship to them □ Friend □ Family □ Co-Worker □ Other _____
If you were not directly referred to our office, how did you find us?
□ Advertisement: _____
□ Attended Seminar: _____

TODAYS DATE: _____
□ Male □ Female
E-mail Address: _____
_____
Cell Phone: (_____) _____-_____
Home Phone: (_____) _____-_____
Work Phone: (_____) _____-_____
Age: _____ Height: _____ Weight: _____
□ Other _____
Their Phone # (_____) _____-_____
_____
□ Convenient Location _____
□ Web Search – keywords: _____
□ Other _____

MEDICAL HISTORY

SURGICAL HISTORY:

1. _____ AGE: _____ DATE: _____
2. _____ AGE: _____ DATE: _____
3. _____ AGE: _____ DATE: _____

ACCIDENT HISTORY:

1. _____ AGE: _____ DATE: _____
2. _____ AGE: _____ DATE: _____
3. _____ AGE: _____ DATE: _____

Date of last physical exam: _____
Have you been treated by a physician for any health condition in the last year? □ Yes □ No
Describe Condition(s): _____
_____
Name(s) and location(s) of Doctor(s) previously seen for present condition(s):
_____
_____

Prescription Medications? □Yes □No
Please describe the condition that the medication is for:

Rx Medication: _____	Condition: _____
Rx Medication: _____	Condition: _____
Rx Medication: _____	Condition: _____
Rx Medication: _____	Condition: _____
Rx Medication: _____	Condition: _____

OTC (over-the-counter) medications? □Yes □No
Please describe the condition that the medication is for:

OTC Medication: _____	Condition: _____
OTC Medication: _____	Condition: _____
OTC Medication: _____	Condition: _____
OTC Medication: _____	Condition: _____

Please Mark ALL **PAST AND PRESENT** Conditions:

	Past	Present	Additional Info
Acid Reflux / Indigestion	□	□	_____
Allergies / Asthma	□	□	_____
Anemia	□	□	_____
Anxiety / Panic Attacks	□	□	_____
Arthritis	□	□	_____
Back Pain	□	□	_____
Bladder / Kidney Trouble	□	□	_____
Bone Fracture	□	□	_____
Bowel Disease	□	□	_____
Cancer	□	□	_____
Catch Colds / Flu Easily	□	□	_____
Chest Pain	□	□	_____
Chronic Fatigue / Tire Easily	□	□	_____
Concussion	□	□	_____
Confusion / Loss of Concentration	□	□	_____
Constipation	□	□	_____
Depression / Weeping Spells	□	□	_____
Diabetes / Hypoglycemia	□	□	_____
Diarrhea	□	□	_____
Dislocated Joints	□	□	_____
Dizziness / Loss of Balance	□	□	_____
Fever / Chills / Sweats	□	□	_____
Fibromyalgia	□	□	_____
Headaches / Migraines	□	□	_____
Head Seems Heavy	□	□	_____
Heart Trouble	□	□	_____
High Blood Pressure / Hypertension	□	□	_____
Immune System Problems	□	□	_____
Irritable Bowel / I.B.S.	□	□	_____
Liver Disease	□	□	_____
Lyme Disease	□	□	_____
Multiple Sclerosis	□	□	_____
Muscular Dystrophy	□	□	_____
Nausea / Vomiting	□	□	_____
Neck Pain	□	□	_____
Nervousness	□	□	_____
Numbness / Tingling	□	□	_____
Rheumatoid	□	□	_____
Ringing / Buzzing in Ears	□	□	_____
Respiratory / Shortness of Breath	□	□	_____
Sleep Problems / Insomnia	□	□	_____
Stress / Anxiety	□	□	_____
Stomach Problems / Ulcer	□	□	_____
Vision Blurred / Sensitive to Light	□	□	_____

Other: _____

Have you ever had a metal implant? □Yes / □No

Have you ever had a gunshot wound? □Yes / □No

Please Check All That Apply **PAST & PRESENT**:

□Epilepsy □Seizures □Convulsions □Chemotherapy □Radiation □Hepatitis □AIDS □HIV □Venereal Disease

For Women Only: Are You Pregnant? Yes / No / I'm not sure Date of last period: _____

PMS Yes / No Menstrual Cramps Yes / No Miscarriage(s) Yes / No

Signature: _____ Date: _____