The Wellness Center 303.357.9355 Medical History Summary

Last Name:_____ **First Name**:_____ **Today's date:** _____

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

Phone: Home# _____ **Work#**_____ **Cell #** _____

E-Mail Address: _____ ***RECEIVE SPECIAL DISCOUNTS*** via our email newsletter!

DOB: _____ **Occupation:** _____

How did you hear about us?

○ Friend: (name) _____

○ Whole Foods ○ Driving by ○ Chair massage downstairs ○ A List

○ Website ○ Yelp.com ○ YellowPages.com ○ Other _____

Have you ever seen the following types of practitioners?

○ Acupuncturist ○ Massage Therapist ○ Chiropractor ○ Nutritionist ○ Naturopathic Doctor

What is your major health concern?_____

Medical History: Please Check if you have a history of the following:

○ Arthritis ○ Asthma ○ Chronic Fatigue ○ High Cholesterol ○ Heart Disease ○ Recent Surgery

○ Hepatitis ○ Cancer ○ Osteoporosis ○Blood Clots ○ Hemophilia ○ Fibromyalgia

○ Edema ○ Epilepsy ○ Varicose Veins ○ High Blood Pressure ○ Postural Problems ○ Diabetes

○ Infectious Disease ○ Thyroid Dysfunction ○ Allergies _____

○ Currently Pregnant (due date_____) ○ Other:_____

Is your current health concern a result of a: ○ Work Injury ○ Auto Accident

Family History:(Has any member of your family had any of the above)? ○ Yes ○ No If yes, which member & what did they have?_____

Circulation: Feelings of: ○Hot ○ Cold What area?_____ ○ Bleed Easily Other:_____

Skin: ○ Dry ○ Itchy ○ Wrinkled ○ Changing Moles or Lumps (cysts/tumors)

○ Boils ○ Dry Scalp ○ Acne ○ Frequent Skin Rashes

○ Burning ○ Moist/Clammy ○ Hives ○ Hair Loss

○ Bruises Easily (Black and Blue Spots) ○ Other:_____

Scars: (List ALL Scars from accidents or surgeries)_____

Head: ○ Headaches (What area?)_____ How often?_____ ○ Dizziness, Vertigo (spinning)

○ Memory Loss ○ Loss of Balance

Musculoskeletal: Pain or signs/symptoms include:

○ Neck ○ Painful Joints ○ Bursitis ○ Upper Back ○ Muscle Spasms/Cramps

○ Lumps ○ Swollen Knees/Elbows ○ Arms/Hands ○ Mid Back ○ Other

○ Fingers ○ Shoulders ○ Leg Cramps at Night ○ Lower Back

○ Bones Sore/Painful ○ Loss of Grip ○ Stiff All Over ○ Loss of Feeling in Hands/Feet

Other (explain):_____

Common Physical Activities: Please check those activities which you are involved in on a regular or daily basis.

___Computer work ___Jogging/Running ___Skiing

___Sitting at desk (How long?_____) ___Yoga ___Tennis

___Sitting in a car (How long?_____) ___Tai Chi/Martial Arts ___Bike Riding

___Aerobics ___Pilates ___Swimming

___Standing (How long?_____) ___Hiking/Walking ___Weight Lifting

___Bending/Lifting Other:_____

Please comment on any activities checked above and note if any condition previously mentioned is aggravated by the above activities:_____

Are you taking any medication? (Prescription, Over-the-counter drugs, Herbs, Vitamins, Bach Flowers, Homeopathic Remedies)

Yes ____ No____ Please list:_____

Are you wearing contacts? Yes_____ No_____ Dentures? Yes_____ No_____

Are you under the care of any health practitioner? Yes___ No___

Please Explain:_____

Name_____**Date**_____

When did your symptoms appear?_____ Is this condition getting progressively worse? _____
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
Type of pain ○ Sharp ○ Dull ○ Throbbing ○ Numbness ○ Aching ○ Shooting
○ Burning ○ Tingling ○ Cramps ○ Stiffness ○ Swelling ○ Other_____

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with your: ○ Work ○ Sleep ○ Daily routine ○ Recreation
Activities that are painful: ○ Sitting ○ Standing ○ Walking ○ Bending ○ Lying down

Chest: ○ Wheezing ○ Trouble breathing at night ○ Mucus rattles when breathing ○ Shortness of breath
○ Palpitations ○ Pain/pressure in chest ○ Persistent cough ○ Hard to breathe
○ Coughing phlegm: what color?_____ what consistency?_____ ○ Coughing blood

Sweating: ○ Night Sweats ○ Rarely sweat ○ Excessive sweating

Blood Pressure: ○ High ○ Low ○ Don't know
Energy Level: ○ High (Time of Day)_____ ○ Low (Time of Day)_____
Stress: ○ None ○ Moderate ○ Severe What causes it?_____

Bowels: ○ Diarrhea ○ Constipation ○ Bloody stools ○ Black stools
○ Mucus In Stools ○ Hemorrhoids ○ Lower bowel gas ○ Stools have foul odor
○ Colon Problems Number Bowel Movements a Day_____ Other:_____

Urine: Color_____Amount_____ Dark/ Light/ Clear
○ Frequent urination ○ Daytime ○ At night ○ Strong smelling urine
○ Hard to urinate ○ Blood in urine ○ Water retention ○ Frequent infections
○ Pain or burning when urinating ○ Other _____

Neurological:

○ Nervousness	○ Depressed	○ Easily angered	○ Easily irritated	○ Numbness/Tingling in limbs
○ Frequent crying	○ Worry/Anxiety	○ Mood Swings	○ Memory confusion	○ Burning in limbs
○ Suicidal	○ Tremors	○ Poor coordination	○ Muscle weakness	○ Feel weak and shaky
○ Seizures	○ Neuralgia	○ Shingles	○ Herniated disc	○ Poor concentration
○ Scoliosis	○ Toes catch on floor when walking			

Females:
Last Monthly Period_____ Last PAP Test_____ Pregnant_____
Age Started Menstrual Cycle?_____ Age Stopped _____
Form of Birth Control _____

○ Menstrual pain ○ Low Backache ○ Irregular ○ Clotting ○ Mood changes
○ Heavy bleeding ○ Light scanty bleeding ○ Color_____ ○ Miss periods
○ Water retention ○ Low or no sex drive ○ Painful breasts ○ Hot flashes ○ Food cravings
○ Other_____ ○ Sexually transmitted disease (past or present) _____
Discharges: ○ Yellow ○ White ○ Thick ○ Odor
○ Itching ○ Liquid ○ Other_____

○ No. pregnancies_____ ○ No. miscarriages_____ ○ No. deliveries_____
○ No. abortions_____ ○ No. Cesareans_____
Any operations: ○ Cervix ○ Uterus ○ Ovaries ○ Other:_____

Males: ○ Low Sex Drive ○ Lack of Sexual Drive ○ Impotence ○Ejaculation Causes Pain
○ Discharge ○ Pain or Burning While Urinating ○ Premature Ejaculation
○ Sexually transmitted Disease (Past, Present)_____ ○ Other:_____

Sleep Problems: ○ Trouble falling asleep ○ Trouble staying asleep ○ Restful ○ Excessive dreaming
How many hours do you sleep a night? _____ ○ What position do you sleep in?_____

Appetite: ○ Excessive appetite ○ Poor appetite ○ Appetite keeps changing
○ Feel tired or weak if a meal is missed ○ Never thirsty
○ Excessive Thirst ○ Other_____

Digestion: ○ Stomach Gas When? _____ ○ Lower bowel gas
○ Heartburn ○ Stomach pain
○ Stomach cramps ○ Burning/Belching
○ Nausea ○ Vomiting
○ Bad breath ○ Sores in mouth
○ Weight gain ○ Weight loss
○ Bitter/Sour taste in mouth ○ Abdominal bloating

Allergies? ○ No ○ Yes If yes, to what?_____

List some of your favorite foods:_____

Cravings: ○ Salt ○ Sugar ○ Spicy ○ Sour ○ Bitter

Dietary Habits: Please check each item listed below if included in your daily or usual diet.

___ Red Meat
___Fish
___Poultry
___Butter
___Milk
___Cheese
___Yogurt
___Protein Supplements
___Food Supplements
___Beans

___Sugar
___Honey
___Baked Goods
___Desserts
___Raw Foods
___Grains
___Nuts
___Seeds
___Fermented Foods

___Coffee
___Black Tea
___Herbal Tea
___Alcohol
___Vitamins
___Water/how much daily _____
___Tobacco use
___Smoke Marijuana
___Indulge in any other recreational drugs

___Soda/soft drinks

_____

Do you have anything else our healthcare providers should know about you?

_____

_____

_____

Consent for Care and Notice of Privacy Practices

This summary discloses how your health information may be used. A full notice of your privacy rights is posted at the front office and can be provided to you upon your request.

I understand that the nature of the recommended medical treatments for my care will be explained to me. I understand that I will have the opportunity to ask questions of those involved in my care. I am not being forced by anyone to accept medical treatment. I consent to the use or disclosure of my protected health information by The Wellness Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or conducting health care operations of The Wellness Center. I understand that a confidential record will be kept and will not be released to others unless they are involved in my care plan. I understand that I may view my medical record and request a copy of it at any time (as dictated by the Health Information Portability and Accountability Act of 1996).

The Wellness Center may use my information to provide appointment reminders, information about treatment alternatives or other health-related issues. The Wellness Center must maintain the privacy of protected health information, abide by the terms of this notice, accommodate reasonable requests I may make to communicate health information by alternative means or alternative locations and obtain my written authorization to use or disclose my health information.

I hereby grant permission to The Wellness Center and its clinicians to perform such examinations and therapeutic treatments as are considered necessary or advised for my diagnosis and treatment plan. Clinicians who treat me include, but are not limited to: medical doctors, naturopathic doctors, acupuncturists, massage therapists, herbalists, nutritionists, physical therapists, and/or chiropractors. My signature on this document indicates my consent for treatment.

I may contact our Director and/or Assistant Director and the Department of Health and Human Services if I believe your privacy rights have been violated. I will not be retaliated against for filing a complaint.

Authorization to Release Information (for insurance clients only)

I authorize The Wellness Center to release any information required to process this claim to any insurance company or attorney. I also authorize any insurance company or medical provider to release my medical records to The Wellness Center. This information is to be used for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of this document is as valid and effective as the original copy.

Payment Agreement and Cancellation Policy

I assume full responsibility for and agree to pay all costs, charges and expenses of every kind and description for services furnished by The Wellness Center. I must pay charges and services not covered by any insurance or other third-party pay or and/or not paid to The Wellness Center for any reason within a time period The Wellness Center deems reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third party responsible for payment of the charges.

The Wellness Center maintains a **strict 4 hour notice of cancellation policy**. Although a courtesy call, email or text is usually made, it is my responsibility to remember and show up for my appointments. Late cancellations and no show appointments will be charged for the full amount of the service.

How do you prefer to be reminded of appointments?

○ Phone ○ Email ○ Text

I have read and completed the above information to the best of my knowledge. I will not hold The Wellness Center, Inc. responsible for any condition, of which they were not informed, which may worsen over time through treatment.

_____ _____

Date Signature of Patient or Legal Guardian