



PATIENT INFORMATION

Date: _____

Name: First _____ Middle Initial _____ Last _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail _____

Marital Status: M S W D P Sex: M F

Date of birth: _____ Age _____

Employer _____ Occupation _____

Name of Spouse/Partners _____

Spouses/Partners date of birth _____

Spouses/Partners Employer _____ Occupation _____

Number of children: _____

Have you ever had chiropractic care before? _____

Where? _____

How were you referred you to this office? _____

*****Insurance (for auto, work comp and personal injury claims): Please present a copy of your insurance card or claim number, contact person's name, phone number, and address to send claims to the receptionist.**

Is this a work related injury? _____

HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date began: _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): _____

Outcome _____

What types of therapy have you tried for this problem(s):

- diet modification
- fasting
- vitamins/minerals
- herbs
- homeopathy
- chiropractic
- acupuncture
- conventional drugs
- other _____

List current health problems for which you are being treated: _____

Current medications (prescription or over-the-counter): _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

- Corrective lenses
- Dentures
- Hearing aid
- Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: see hear taste smell feel hot/cold sensations

move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty

Strong dislike for any one of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty

Do you: Prefer warmth (i.e., food, drinks, weather, etc.) Prefer cold (i.e., food, drinks, weather, etc.) No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

Time of day you feel the worst or your symptoms are aggravated:

- 7 a.m. - 9 a.m.
- 9 a.m. - 11 a.m.
- 11 a.m. - 1 p.m.
- 1 p.m. - 3 p.m.
- 3 p.m. - 5 p.m.
- 5 p.m. - 7 p.m.
- 7 p.m. - 9 p.m.
- 9 p.m. - 11 p.m.
- 11 p.m. - 1 a.m.
- 1 a.m. - 3 a.m.
- 3 a.m. - 5 a.m.
- 5 a.m. - 7 a.m.

- 7 a.m. - 9 a.m.
- 9 a.m. - 11 a.m.
- 11 a.m. - 1 p.m.
- 1 p.m. - 3 p.m.
- 3 p.m. - 5 p.m.
- 5 p.m. - 7 p.m.
- 7 p.m. - 9 p.m.
- 9 p.m. - 11 p.m.
- 11 p.m. - 1 a.m.
- 1 a.m. - 3 a.m.
- 3 a.m. - 5 a.m.
- 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

- Debilitating fatigue
- Shortness of breath
- Insomnia
- Constipation
- Chronic pain/inflammation
- Depression
- Panic attacks
- Nausea
- Fecal incontinence
- Bleeding
- Disinterest in sex
- Headaches
- Vomiting
- Urinary incontinence
- Discharge
- Disinterest in eating
- Dizziness
- Diarrhea
- Low grade fever
- Itching/rash

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Age of first period _____
- Date of last gynecological exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section
- Surgical menopause
- Menopause
- Date of last menstrual cycle _____
- length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
Cigarettes: #/day _____
Cigars: #/day _____
- Alcohol:
Wine: #glasses/d or wk _____
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____
- Caffeine:
Coffee: #6 oz cups/d _____
Tea: #6 oz cups/d _____
Soda w/caffeine: #cans/d _____
Other sources _____
- Water: #glasses/d _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
 dairy wheat eggs
 soy corn all gluten
- Other _____

Food Frequency

- Servings per day:
Fruits (citrus, melons, etc) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other _____

Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)



Financial Policies and Guidelines

Total Health and Healing Center is a "fee for service" practice and Payment is due at the time of service. If you have insurance, we must emphasize that, as a wellness center, our relationship is with you, not your insurance company.

As a courtesy, we can provide our patients with a coded receipt to submit for reimbursement of any chiropractic coverage. Many of our services are considered preventative/ wellness care and therefore will not be covered by most insurance. We are under no obligation to provide Doctor's notes to your insurance company.

When you schedule a personalized appointment for your healthcare needs, that time is set aside for you. If you need to reschedule your appointment, we ask that you give us a minimum of 24 hours notice. We reserve the right to charge for any appointments missed without this notice. If you have a package, we will deduct that from your total.

Due to federal guidelines, we are unable to offer discount packages to patients submitting to Medicare. Many patients who have Medicare and are on a wellness program request that we not submit so they can take advantage of the package discounts.

*Supplement discounts applied to homeopathic remedies, medical foods, and nutritional supplements. The office visit package excludes the cost of orthotics, fitness bands, etc.

If at any time during the treatment period the package owner chooses to discontinue treatments, they will be reimbursed the remainder of their balance, minus all the discounts they have received to date. If a credit card was initially used to purchase the package a 3% processing fee will be applied to return. Notice must be given in writing and reimbursement will be made in one weeks' time in the form of a check.

Prices listed include 2% MN care tax.

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS REGARDING THE FINANCIAL POLICIES AND GUIDELINES.

PRINT NAME _____

SIGNATURE _____

DATE _____