

Welcome to FIT Wellness Center – Personal Concerns & History

Full Name: _____ Date of Birth: _____ Date: _____

Please answer the following important questions *completely* to help us enable you to achieve your desired activity level:

Reason(s) for seeking care:

What concern(s) do you feel we can address for you?

Pain/Discomfort Least 1 2 3 4 5 6 7 8 9 10 Worst

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What makes the concern(s) better: _____ worse: _____

Do your concern(s) stay in one spot or move (i.e.: down arms, legs...): _____

Your goals (*Check all that apply*):

- Focused/Pain Relief Care...I only care about my current concern(s).
- Focused/Pain Relief & Maintenance Care...I only care about my current concern(s) & preventing its return.
- Correction & Maintenance Care...I want optimum health & well-being & can commit to long-term care.

History:

Have you ever received (*check all that apply*): Chiropractic Acupuncture Massage

With whom? _____

Date of last visit: _____ Why did you stop care? _____

Have you been treated by a Doctor for any health condition in the last year? Yes No

If yes, please describe: _____

Please list your family history: _____

Do you exercise regularly? Y N What type/how often? _____

Do you take vitamins/supplements regularly? Y N What/how often? _____

List medications you take: _____

Women: Are you pregnant? Y N Date of last cycle: _____ Do you have normal cycles? Y N

Much of trauma to the spine & nervous system can occur in the early years. Please indicate to the best of your ability how your mother's pregnancy, birth & early years with you were: _____

Trauma: Have you *ever* had trauma from? Automobile Work Recreation Slips/Falls Other: _____

Please explain how & when: _____

Injured your spine (head, neck, back, tailbone, hips)? Y N How & when: _____

Broken any bones or sprain/strained any part of your body? Y N How & when: _____

Any surgeries (ie joint replacements, pacemaker, etc) or hospitalizations? Y N What & when: _____

Chemical Stress: Ever been exposed to chemical stress (i.e. pollution, fumes, smoke, alcohol, coffee, food, drugs, prescriptions, vaccinations, etc)? Y N How & when: _____

Cognitive Stress: Have you had anything that has or is currently causing increased emotional/cognitive stress? Y N What & when: _____

Please fill out the forms: **Patient Health Questionnaire (PHQ), Neck Index, & Back Index** *completely!*