Clayton Wellness Center

Stefanie Sanger Woollen, D.C., J.D.
Rebecca Sturmer, D.C.

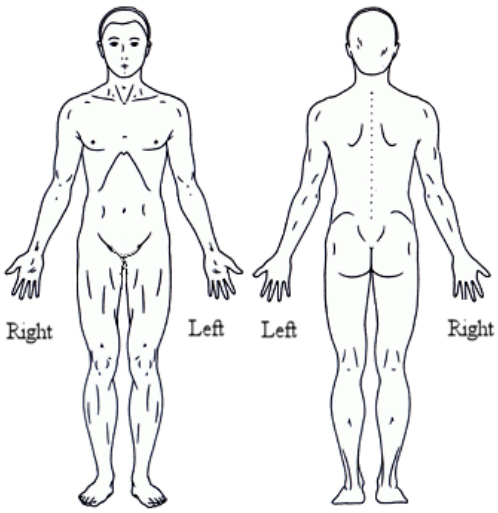
CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION: Date _____
Full Name _____ Age _____ Date of Birth ____/____/_____ Sex _____
Full Name of Parent or Legal Guardian_____
Phone # (C) _____ (H) _____ (W) _____ (Circle preferred number to call)
Address _____ City _____ State_____ Zip_____
Email Address (if okay to email for treatment related communication): _____
Occupation_____ Employer _____
Marital Status _____ Number of Children _____ Females only: Number of Pregnancies _____
In case of emergency, contact: _____ #_____ #_____
Referred by: _____

HEALTH REPORT:
Reason for seeking care: _____
_____
How long have you had these symptoms? _____Have you received previous treatment for this? Yes___ No___
List any diagnosis given previously: _____
Is your present condition due to an injury? Yes ___ No ___ On the Job ___ Auto Accident ___ Other _____
Have you previously received chiropractic care for any reason? Yes ___ No ___ If yes, date of last visit: _____
Are you currently under the care of a different physician? Yes ___ No___
If yes, name and reason: _____
Are you currently taking medication or supplements? Yes___ No___ If yes, please list: _____
_____
List the approximate dates and types of any surgery or other significant treatments: _____
_____
Please list any complimentary, alternative or supportive treatments you have tried or received for any condition:
_____

Family History:
Father: Living ___ Deceased ____ If deceased, cause and age when deceased: _____
Health conditions over lifetime: _____
Mother: Living ___ Deceased ____If deceased, cause and age when deceased: _____
Health conditions over lifetime: _____
Siblings (any conditions suffered): _____

Habits:
Tobacco use now? Yes___ No___ If so, how much? _____ If no, do you have a past history of tobacco use? Yes___ No___
Do you drink alcohol? Yes___ No___ If yes, how often? Daily ___ Weekly___ Social Occasions ___
How many caffeinated drinks to you have per day? _____
Recreational drug use? Now / Past / Never Do you get adequate sleep/rest? Yes___ No___
Physical Activity Level (on average): Light___ Moderate___ Heavy___ Do you have a gym membership? Yes___ No___



Symptoms:
Please circle your degree of pain or discomfort: 0=none, 10=severe
0 1 2 3 4 5 6 7 8 9 10
Using the symbols below, mark on the picture where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +

What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is this condition worse during certain times of the day? Yes___ No___
Is this condition interfering with:
Work?___ Sleep?___ Daily routine?___ Other: _____
Is this condition progressively getting worse? Yes___ No___

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Please mark each item below for each sign or symptom you <u>currently have (C) or previously had (P):</u>

GENERAL SYMPTOMS
__ Seasonal Allergies
__ Depression
__ Dizziness
__ Fainting
__ Fatigue
__ Headache
__ Loss of Sleep
__ Mental Illness
__ Nervousness
__ Numbness/Tingling
__ Weight Loss/Gain

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Arthritis/Rheumatism
__ Weak Muscles
__ Sprains/Strains
__ Broken Bones

SKIN
__ Boils
__ Bruising Easily
__ Dryness/Itching
__ Eczema/Rash/Dermatitis
__ Hives
__ Sensitive Skin
__ Allergy

RESPIRATORY
__ Asthma
__ Chest Pain
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Phlegm or Blood
__ Wheezing or Difficulty Breathing

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid/Goiter
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinus Infections
__ Sore Throats
__ Hoarseness
__ Gum Trouble
__ Tonsillitis

GENITO-URINARY
__ Bed Wetting
__ Bladder Infection
__ Blood in Urine
__ Kidney Infection
__ Kidney Stones
__ Painful Urination
__ Prostate Problems
__ Decreased Flow/Force
__ Urgency/Frequent Urination
__ Loss of Bladder Control

CARDIO-VASCULAR
__ High/Low Blood Pressure
__ Hardening of Arteries
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Irregular Pulse
__ Palpitations
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Stroke
__ Swelling in Ankles
__ Varicose Veins

GASTRO-INTESTINAL
__ Food Allergy/Hypersensitivity
__ Abdominal Pain
__ Belching/Gas
__ Colon Problems
__ Colitis or Crohn's
__ Diverticulitis
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Hernia
__ Hemorrhoids
__ Heart Burn
__ Intestinal Worms
__ Jaundice
__ Liver/Gallbladder Trouble
__ Bloody or Black Stool
__ Nausea
__ Painful Defecation
__ Poor Appetite
__ Poor Digestion
__ Ulcer
__ Vomiting
__ Vomiting Blood
__ Weight Loss/Gain

WOMEN'S HEALTH
__ Birth Control: _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
__ Currently Pregnant
__ Date of last period _____

Please mark any of the following conditions you currently or previously suffered from:
__ Alcoholism
__ Anemia
__ Cancer
__ Diabetes
__ Edema
__ Emphysema
__ Epilepsy
__ Gout
__ Hepatitis
__ Herpes
__ HIV/AIDS
__ Malaria
__ Measles
__ Multiple Sclerosis
__ Mumps
__ Osteoperosis/Osteopenia
__ Pneumonia
__ Polio
__ Rheumatic Fever
__ Thyroid Disease
__ Tuberculosis
__ Ulcers

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health and personal information. I agree to allow this office to examine me for further evaluation. If patient is a minor child, the parent or legal guardian shall sign this form.

Patient or Parent/Guardian Signature_____ Date_____

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