Welcome to Angelic Wellness!

We are here to serve you to the best of our ability. In order to do that, we ask that you fill in the following as accurately as possible.

Date_______________
Name(First, middle, last)____
What do you prefer to be called?____

Mailing address____
City, State, Zip____
Home Phone________________________________ Cell______________________________________
e-mail____
Alternative address____
City, State, Zip____
Phone_________________________________

Employer___________________________________Phone____________________________________
SS#___________________________ Occupation or what you retired from_________________________
Address____
City, State, Zip____

Marital Status_____________________________ Gender MALE FEMALE
Age_______________ Date of Birth_______________________
Weight____________ Height____________

Spouse or Emergency Contact Name (circle one)____
Phone________________________________
Spouse's Occupation or what they retired from____

How did you hear about us? Phone book Internet BNI Drove by Friend who?__________________

Angelic Wellness is considered a cash practice in that we expect payment in full at the time of service. We will submit your insurance for you and will do the best we can to get you paid. However, ultimately you are responsible for paying for your care and getting your insurance company to pay you.

Insurance Carrier____
Please give us your insurance card and photo ID if you want us to submit to your insurance carrier.

Do you consider this condition to be (please circle one)
Chronic condition Congenital problem Acute (new) issue Date problem started______________

To serve you to the best of our ability, we need to know as much about you as possible. Please take the time to fill in your information. It really is that important!

What are your health and wellness goals?____
If you are here for wellness and have no complaints, please forgive the questions that do not pertain to you.

IT IS ESSENTIAL THAT YOU FILL OUT THIS SHEET FOR EACH COMPLAINT YOU WOULD LIKE TREATED

What **one** main health issue brings you here____

Pain Description (circle)

Aching	burning	cramping	deep
Dull	itching	numbing	numbness
Pins & needles	radiating	shooting	sharp
Painful soreness	painful tension	painful tightness	spasming
Stabbing	stiffness with pain	superficial	throbbing
Tingling	other____		

For each of the above that you have circled, please place a number next to it indicating how severe

1 mild 2 mild to moderate 3 moderate 4 moderate to severe 5 severe

Condition onset: When did this start?____

If there is a date of injury, tell us when and how?____

Overall Pain rating (circle)

No Pain Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

Circle one please

With activity without activity with and without activity with work without work

Circle one please

Sporadic intermittent constant occasional persistent constant varies none

If the pain radiates, where does it go?____

Aggravating factors (circle)

Bending	coughing	driving	exercise
Head rotation	household chores	lying on back	lifting
Looking down	looking up	movement	rapid movements
Reaching	resting	scooping	sitting
Sleeping	sneezing	stairs	standing
Stooping	straining	twisting	typing
Walking	working	Other____	

Relieving Factors (circle)

Adjustment provided	Topical analgesic	Lying on back with knees up
Exercises/Stretches	Heat	Ibuprofen, aspirin, etc
Ice	Lying down	Leaning against a support
Massage	Medication	Movement
No movement	Resting	Sitting
Standing	Walking	Other____________________________________

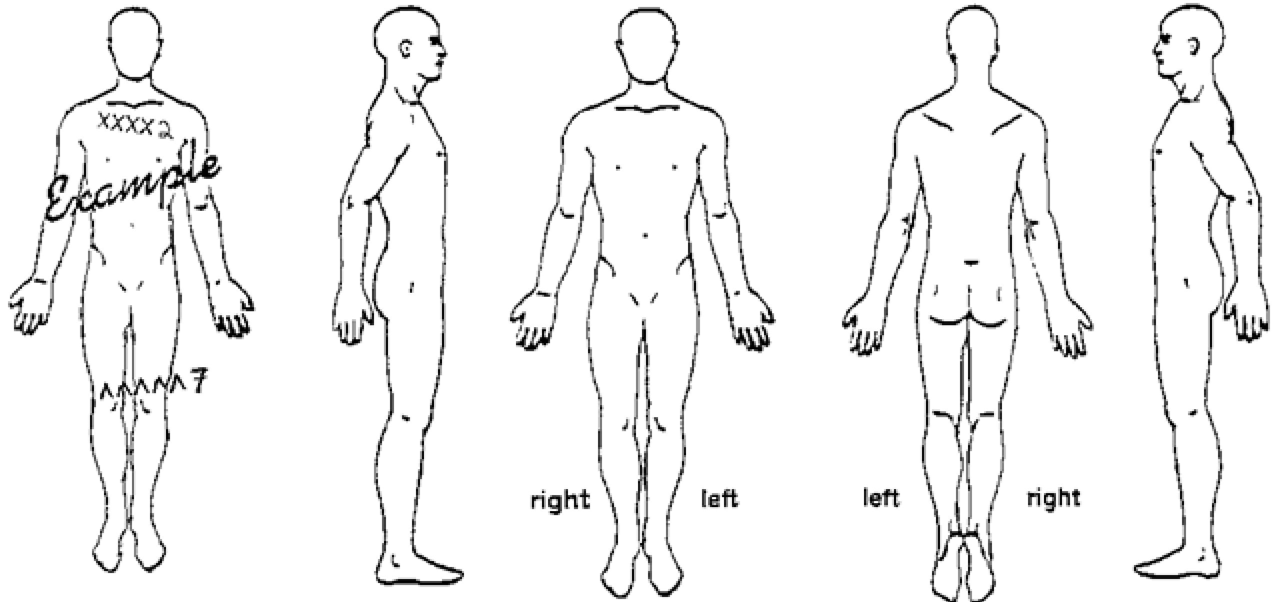
If there was an injury, did you have pain here before that injury?(circle) YES NO

Have you had this condition before this event?(circle) YES NO

What other doctors have you seen for this condition?____

Please show us where you are experiencing symptoms…
Indicate your degree of pain using a scale of 1 (minor discomfort) to 10 (extreme pain):

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	0 0 0 0 0 0 0	^ ^ ^ ^ ^	X X X X	/ / / / / / / /



Has your condition caused you to lose enjoyment in (Circle all that apply)
Hobbies   Personal Activities   Sports   Work

Has your condition caused you duress in work or school?   YES   NO

Has your condition caused you duress in your household duties?   YES   NO

If you have lost time from school or work due to this condition, how much?___________________

Activities of Daily Living
Please circle any of the following that you are not doing as well as you feel you should.
Bathing   driving   getting in and out of car   caring for children   lifting children
Playing with children   computer   dressing   eating   feeding self   grooming
Cleaning   cooking   dishes   laundry   yard work   managing finances
Managing medications   oral care   paperwork   caring for pet/s   phone
Reading   religious events   sex   shopping   sitting   sleeping   social activities
Stairs   standing   toileting   walking   working   writing
Other____

For each of the above that you have circled, please place a number next to it indicating how severe
1 mild   2 mild to moderate   3 moderate   4 moderate to severe   5 severe

Medications currently taking (we are happy to make a copy of any list that you carry☺)
____

____

Please list any **medical or psychological** issues you are being treated for___________________________

____

Please list any **surgeries, hospitalizations or injuries** you have had_______________________________

____

Please list any **herbs, vitamins, home remedies, homeopathic remedies**___________________________

____

Please circle any condition/s that apply to your **immediate family** (mom, dad, siblings, children)

Alcohol abuse	Allergies	Anemia
Anxiety	Arthritis	Asthma
Cancer	Cancer, breast	Cancer, colon
Cataracts	Depression	Diabetes
Digestive problems	Drug abuse	Emphysema
Endometriosis	Hay fever	Hearing problems
Heart attack	Heart disease	High blood pressure
High cholesterol	Inflammatory bowel	Kidney problems
Lung problems	Mental illness	Migraines
Neurological disease	Physical abuse	Positive TB test
Stroke	Thyroid problems	Ulcer

Other____

Marital Status single married widowed divorced other

Alcohol Use (How much?)

Beer	__________	a day	a week	a month	a year
Wine	__________	a day	a week	a month	a year
Liquor	__________	a day	a week	a month	a year

Tobacco Use (How much?) N/A____ Cigarettes ____ Cigars____ Chewing tobacco____ Pipe____

Liquids Consumed (how much per day?)

Water_____	Reg. Coffee_____	Decaf. Coffee_____	Energy Drinks_____
Tea, Black_____	Tea, Decaf._____	Tea, Green_____	Tea Herbal_____
Diet Soda_____	Regular Soda _____		

Recreational interests ____

Hobbies____

On a typical day, **what do you eat** for the following meals
Breakfast____
Lunch____
Dinner____
Snacks____

How many hours do you typically **sleep** each night______________________________

Exercise routine including hours per week____
____

Constitution: lack of appetite fatigue fever weight stable weight loss weight gain

Eyes/Head: blurred vision corrective lenses dizziness double vision eye discharge eye pain headache lightheaded visual changes visual disturbance other_____________________________

ENT/Upper respiratory: allergy bad breath bridges dental implants dentures difficulty swallowing ear pain ear infection ear discharge ears ringing goiter hearing loss lightheaded mouth pain mouth sore nose discharge nosebleed sinus congestion sinus issues sinus pain snoring sore throat loss of teeth other___________________________

Cardiovascular: asthma chest pain cough difficulty breathing difficulty lying flat fainting spells heart problems history of heart disease mucus with color murmur palpitations problems with cholesterol levels shortness of breath with exertion swelling/edema in extremities swollen ankles varicose veins other____

Respiratory: bronchitis chills cough coughing blood emphysema lung disease smoking wheezing other____

Gastrointestinal: abdominal pain bloody stool change in BMs constipation diarrhea heartburn/reflux hemorrhoids hernia indigestion jaundice nausea vomiting other____

Genitourinary: abnormal discharge bladder infection bladder leakage childbirth discharge from penis hysterectomy incontinence jaundice kidney infection kidney pain kidney stones miscarriage pregnancy abnormal pregnancy prostate enlarged prostate symptoms STDs urinate more than twice a night unusual discharge or bleeding frequent urination loss of control of urination painful urination Blood in urine urine clear urine yellow other____

Musculoskeletal: arthritis backache cramps headaches joint pain limited motion muscle pain muscle weakness neck pain sore muscles sports injuries muscle stiffness swelling in joints other____

Skin and Breast: acne breast discharge breast lumps breast painful change in skin color change in hair change in nails change in skin texture dermatitis dryness eczema fungal infection growths itchiness lumps pimples psoriasis rashes shingles sores suspicious moles warts yeast infection other____

Neurological: concussion convulsions diabetes dizziness fainting head trauma headaches memory loss multiple sclerosis neuropathy numbness paralysis Parkinson's disease pins & needles restless legs seizures tingling tremors unable to move parts of body vertigo visual disturbances weakness other____

Mental: anger issues anxiety confusion depression difficult sleeping memory loss mental illness mood swings nervousness sadness tension other________________________________
Do you want us to help you naturally with this condition YES NO

Endocrine: ankle swelling diabetes excessive appetite excessive hunger excessive thirst excessive urination fatigue hair loss heat/cold intolerance hysterectomy postmenopausal early signs of menopause significant weight change skin changes thyroid issues weakness
Other____

Hematologic/Lymphatic: anemia blood clots B12 deficiency easy bruising enlarged glands problems with cholesterol levels sore lymph nodes swelling in extremities
other____

Allergic/Immunologic: environmental allergies food allergies frequent infections hay fever HIV/AIDS hives lupus medication allergies pet allergy rheumatoid arthritis
other____

Payment is required at the time of services and / or supplies are rendered. We accept cash, personal checks and major credit cards. We do not accept Medicare or medical insurance assignments. We do file Medicare claims and we will file medical insurance claims for policies that cover chiropractic care. Any payments made by Medicare or other medical insurance carrier will be paid directly to the patient.

If you are on Medicare, please provide us with your Medicare card or Medicare Primary Carrier card. If you have medical insurance that covers chiropractic care, and would like us to file claims for you, please provide us with your insurance card. We file insurance claims at least monthly. If you prefer, we are happy to provide you with a receipt so you may file your own insurance claims.

____

I understand and agree that Medicare and medical insurance policies are an arrangement between the insurance carrier and me. I understand and agree that all services and /or supplies rendered me are my personal financial responsibility. Further, I authorize Angelic Chiropractic & Health Services, Inc. to provide any information necessary to process claims on my behalf. I understand that it is my responsibility to inform the office of any changes in my personal information and medical status. I understand the above information and guarantee this form was completed to the best of my knowledge and understanding. I further understand that chiropractic adjustments may alter the way I use my muscles and shift my structure and that this process of change may cause soreness such as that experienced after exercising.

Signature____ Date_______________________