



# Welcome to Angelic Wellness

## *About you*

Date: \_\_\_\_\_  
Name (First, MI, Last): \_\_\_\_\_  
What do you preferred to be called? \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email address: \_\_\_\_\_

Alternative Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone number: \_\_\_\_\_  
SSN#: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Gender: Male Female  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Weight \_\_\_\_\_  
Height \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
Spouse's Phone \_\_\_\_\_  
Spouse's Occupation \_\_\_\_\_  
Please tell us how did you hear about us? \_\_\_\_\_

In order to completely understand your situation please fill out the following pages as thoroughly as possible.



# Health & Wellness Goals

Welcome to Angelic Wellness. Our goal is your health and wellness!

What are your health and wellness goals? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name, address, and telephone number of the last doctor who put you on a health development program. \_\_\_\_\_  
\_\_\_\_\_

Were you able to stay on the program? Y N If yes, for how long? \_\_\_\_\_

What were your results? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were your results permanent? Y N

Are you healthier today than you were 5 years ago? Y N

If so, what did you do to improve your health? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If not, why do you think your health declined? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you expect to be healthier 5 years from now? Y N

If so, what are you planning to do to improve your health, and, if not, what could you do to improve your health rather than have it continue to decline? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you like your health to be 5 years from now? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Symptoms You May be Experiencing

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Please tell us any symptoms or problems you are having in the area of your main concern? \_\_\_\_\_

Is this the result of an auto accident, sports injury, work injury, trauma or chronic problem? What happened? \_\_\_\_\_

When did it start? \_\_\_\_\_

Please describe your pain (if any) and its location. \_\_\_\_\_

Did this come on slowly or suddenly? \_\_\_\_\_

What makes it better or worse? \_\_\_\_\_

Is your pain any of the following? Y N N/A (Please Circle)  
Stabbing Achy Sharp Burning Throbbing  
Mild Moderate Severe  
Constant Intermittent

Is it worse in the morning or evening? \_\_\_\_\_ Does it wake you up at night? Y N

Is it painful only with motion? Y N Is it also painful when you are still? Y N

What activities of daily living is this preventing or hindering you from doing?

Have you seen other doctors for this? Y N If yes, who? \_\_\_\_\_

What did they do? \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

What has helped? \_\_\_\_\_

Please circle the number that best describes the question being asked regarding your primary symptom.

What is the status of your primary symptom right now?

None 0 1 2 3 4 5 6 7 8 9 10 Worst possible

What is the status of your primary symptom on average?

None 0 1 2 3 4 5 6 7 8 9 10 Worst possible

What is the status of your primary symptom at its best?

None 0 1 2 3 4 5 6 7 8 9 10 Worst possible

What is the status of your primary symptom at its worst?

None 0 1 2 3 4 5 6 7 8 9 10 Worst possible

Please circle the effect your symptoms have on your performance using the following key:

“N/A” – Not applicable

“Moderate” – Painful (limited ability)

“No Effect”

“Moderate/Severe” – Very Limited

“Mild” – Painful (can do)

“Severe” – Cannot do

### **Employment**

Job Performance      N/A No Effect Mild Moderate Moderate/Severe Severe

### **Daily Activities**

Bending	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Care-Infirm Family	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Carrying Groceries	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Change Position (Stand/Sit)	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Climb Stairs	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Driving	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Extended Computer Use	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Eating	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Household chores	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Kneeling	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Lifting Children	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Lifting Other	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe

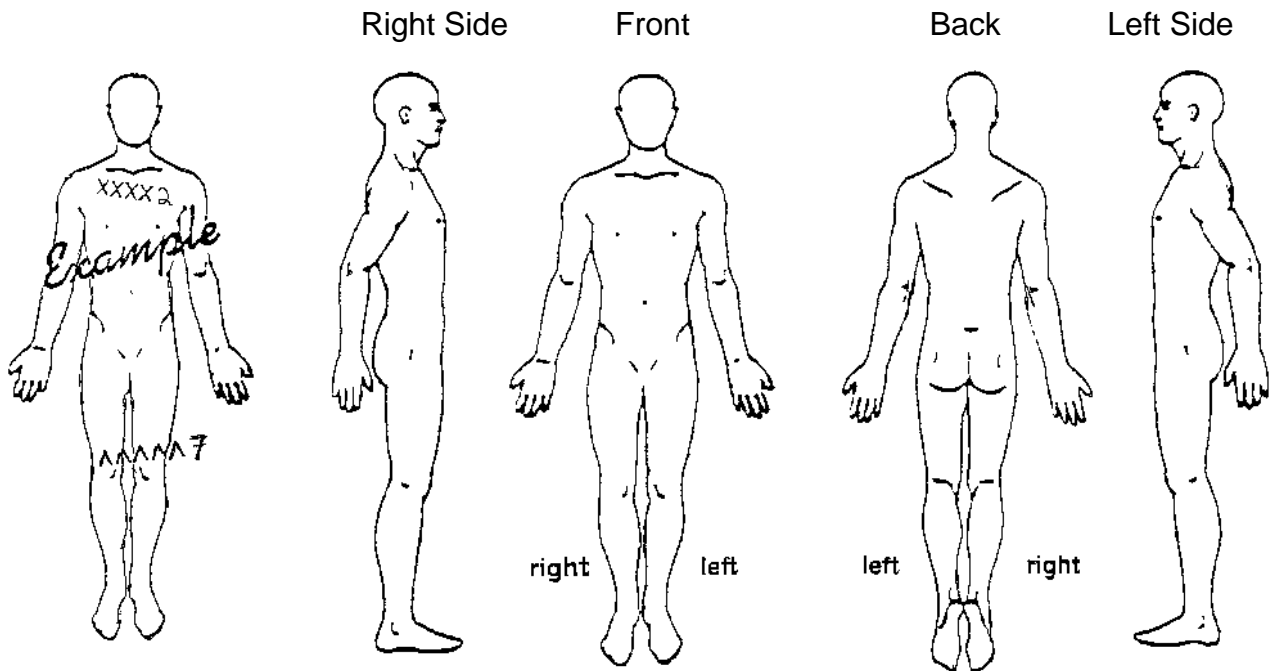
Pet Care	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Reading (Concentration)	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Bathing	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Dressing	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Shaving	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Sexual Activities	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Sleep	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Sitting Still	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Standing Still	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Walking	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
Yard Work	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe

**Recreational Activities**

_____	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
_____	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
_____	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe
_____	N/A	No Effect	Mild	Moderate	Moderate/Severe	Severe

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      ^ ^ ^ ^ ^      X X X X      / / / / / / / /



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## Your Body Systems

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Usual Blood Pressure: \_\_\_\_\_ Usual Respiratory Rate: \_\_\_\_\_  
Usual Pulse: \_\_\_\_\_ Usual Body Temperature: \_\_\_\_\_

**SKIN** Have you noticed any of the following? Y N (Please circle)  
Color Change      Texture Change      Rashes      Sores      Lumps  
Eyebrow Change      Hair Change      Itchiness      Dryness      Nail Change

**HEAD** Have you noticed any of the following? Y N (Please circle)  
Headaches: Y N If yes, location / how often? \_\_\_\_\_  
Heavy Headed      Light Headed      Dizziness      Visual Changes  
Eye Pain      Eye Discharge      Hearing Loss      Ear Pain  
Ear Infections      Ear Discharge      Ear Ringing      Sinus Pain  
Nose Discharge      Nosebleeds      Snoring      Allergies  
Mouth Pain      Mouth Sores      Bad Breath      Goiter  
Difficult Swallowing      Sore Lymph Nodes  
Corrective Lenses? Y N      Do you floss regularly? Y N

**CHEST** Have you noticed any of the following? Y N (Please circle)  
Pain      Palpations      Difficulty Breathing      Asthma  
Asthma      Cough      Mucus with color  
Do you have a history of heart problems? Y N

**BREAST** Have you noticed any of the following? Y N (Please circle)  
Pain      Lumps      Discharge

**ABDOMEN** Have you noticed any of the following? Y N (Please circle)  
Nervousness      Nausea      Vomiting      Pain      Heart Burn  
Gas      Bloating      Constipation      Diarrhea      Hemorrhoids  
Do you have a gall bladder? Y N  
How often do you have a bowel movement? \_\_\_\_\_  
What color is your stool? Light      Medium      or      Dark Brown

**FEMALE ONLY** Have you noticed any of the following? Y N (Please circle)  
PMS      Bloating      Cramps      Mood Swings      Hot Flashes  
Night Sweats      Weight Change      Vaginal Discharge      Sexual Dysfunction  
Breast Tenderness with cycle  
Date of last period? \_\_\_\_\_ Are you using birth control? Y N  
Are you using birth control?  
Are you nursing? Y N      Menopause started at what age? \_\_\_\_\_  
Do you perform regular self exams? Y N  
Have you had a breast biopsy? Y N      Benign? Y N

**MALE ONLY** Have you noticed any of the following? Y N (Please circle)  
Prostate Pain Pain/Swelling in Scrotum Discharge from Penis  
Sexual Dysfunction Urination Urgency Difficulty starting stream

**URINARY TRACT** Have you noticed any of the following? Y N (Please circle)  
Kidney Pain Frequent Urination Painful Urination Incontinence  
What color is your urine? \_\_\_\_\_  
How many times a night do you urinate? \_\_\_\_\_  
Do you have a history of kidney/bladder infections? Y N

**PERIPHERAL VASCULAR** Have you noticed any of the following? Y N  
(Please, circle)  
Swelling Hands Legs Feet  
Numbness Hands Legs Feet  
Coldness Hands Legs Feet  
Cramps Hands Legs Feet

**MENTAL STATUS** Have you noticed any of the following?  
Nervousness Tension Confusion Mood Swings Depression  
Loss of Memory  
Do you have emotional issues you would like to conquer naturally? Y N

**HEMATOLOGY** Please bring a copy of your last blood  
Date of last blood profile? \_\_\_\_\_ Profile if available.  
Cholesterol level \_\_\_\_\_  
Glucose level \_\_\_\_\_  
Thyroid level \_\_\_\_\_  
Do you bruise easily? Y N

**ENDOCRINE** Have you noticed any of the following? Y N (Please circle)  
Excessive Thirst Excessive Hunger Excessive Urination Fatigue  
Ankle Swelling Weakness Sudden Weight Change Skin Getting Darker

**MUSCLOSKELETAL** Have you noticed any of the following? Y N  
(Please circle)  
Joint Pain Y N If yes, where? \_\_\_\_\_  
Limited Motion Y N If yes, where? \_\_\_\_\_  
Stiffness Y N If yes, where? \_\_\_\_\_  
Sore Muscles Y N If yes, where? \_\_\_\_\_

**NERVOUS SYSTEM** Have you noticed any of the following? Y N  
(Please circle)  
Fainting Seizures Tremors Restless Legs Numbness  
Pins/Needle Paralysis where: \_\_\_\_\_

# Your Social History



## SMOKING

Do you smoke? Y N

If yes, how much? \_\_\_\_\_

If yes, for how long? \_\_\_\_\_

Have you ever smoked? Y N When did you quit? \_\_\_\_\_

Would you like help quitting? Y N

## SLEEP

How many hours do you sleep at night? \_\_\_\_\_ Do you wake often? Y N

How old is your mattress? \_\_\_\_\_ Is it comfortable? Y N

What time do you go to bed? \_\_\_\_\_ When do you get up? \_\_\_\_\_

## SEX

Are you sexually active? Y N Do you have multiple partners? Y N

Do you have a history of venereal disease? Y N Are you HIV positive? Y N

## DRUGS

Do you take any prescription drugs? Y N

If yes, please list them with the reason for taking them.

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Are you on hormone replacement therapy? Y N

Please list any over the counter medications you take regularly.

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Please list any vitamins, home remedies, homeopathics, herbs and the reason you take them.

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## DIET

How many meals do you eat each day? \_\_\_\_\_

What do you usually eat for:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

How much do you drink each day:

Water _____	Soft drinks _____
Juice _____	Tea _____
Coffee _____	Decaf Coffee _____
Wine _____	Beer _____
Alcohol _____	

### EXERCISE

How many times a week do you:

Stretch _____
Strength Training _____
Aerobic _____

### ADDITIONAL INFORMATION

Please add anything else you feel the doctor should know before treating.

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# *Six* In event of emergency

Who should we contact? \_\_\_\_\_

Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work: \_\_\_\_\_

## Your health team

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Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Massage Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_

Acupuncturist: \_\_\_\_\_ Phone: \_\_\_\_\_

Physical Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Personal Trainer: \_\_\_\_\_ Phone: \_\_\_\_\_

Other: \_\_\_\_\_ Phone: \_\_\_\_\_



# Your Past History

Have you ever experienced this before? Y N How long did it last? \_\_\_\_\_

What did you do for it? \_\_\_\_\_

What helped? \_\_\_\_\_

Have you been to a chiropractor in the past? Y N

How often did you go? \_\_\_\_\_

How long has it been since you were adjusted? \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

Are you currently under the care of any doctor for any other condition? Y N

If yes, what? \_\_\_\_\_

Have you ever had? (Please circle, if yes)

- |          |           |                   |                 |                  |
|----------|-----------|-------------------|-----------------|------------------|
| Measles  | Mumps     | Rubella           | Whooping Cough  | Chicken Pox      |
| Shingles | Hepatitis | Polio             | Rheumatic Fever | Scarlet Fever    |
| TB       | Diabetes  | Cancer (describe) |                 | Other (describe) |

\_\_\_\_\_  
\_\_\_\_\_

Surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sprains or Fractures:

\_\_\_\_\_  
\_\_\_\_\_

Major Infections:

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Immunizations:

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Major Traumas:

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Allergies:

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## Your Family History



Please indicate with a "Y" (for yes) who in your immediate family (mother, father, siblings, grandparents, children or spouse) has had any of the following.

	Mother	Father	Siblings	Grandparents	Children	Spouse
Cancer (type)						
Heart Disease						
Stroke						
Diabetes						
Arthritis						
Tuberculosis						
Kidney Disease						
Epilepsy						
Headaches						
Other						

Are your parents still living? Mother: Y N Father: Y N

If not, how did they pass and what age?

Mother: \_\_\_\_\_

Father: \_\_\_\_\_



## *Our Policy*

Payment is required at the time services and/or supplies are rendered. We accept cash, personal checks, MasterCard, VISA and Discover. 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for choosing our clinic for your health and wellness care!  
Please bring this completed form with you to your first visit or email it to [AngelicChiro@aol.com](mailto:AngelicChiro@aol.com)

# Angelic Extreme Wellness Makeover Application

Name \_\_\_\_\_ Date \_\_\_\_\_  
Phone \_\_\_\_\_ email \_\_\_\_\_

In order to serve you better, please fill out this form with as much detail as possible. This will help us to determine if our program is right for you. Please do not feel limited by the space provided on this form. Make answers as long as needed by using the insert button on your keyboard. Your personal situation is very important to us. If you answer no to any question please tell us why. Thank you for your interest in taking this huge step toward wellness, you deserve it.

What are your wellness goals? \_\_\_\_\_  
\_\_\_\_\_

Why is it important to you to be involved in this program? \_\_\_\_\_  
\_\_\_\_\_

If you do not change your lifestyle soon, predict your health future. Why?  
\_\_\_\_\_

How will changing your lifestyle affect your family? \_\_\_\_\_  
\_\_\_\_\_

Do you have the support of your friends and family in joining this program? \_\_\_\_\_

Are you willing to change your diet? \_\_\_\_\_

Are you willing to exercise regularly? \_\_\_\_\_

Are you willing to get chiropractic adjustments? \_\_\_\_\_

Are you willing to meet with a wellness coach weekly? \_\_\_\_\_

Are you willing to keep a daily journal of your food and beverage consumption, exercise and energy levels? \_\_\_\_\_

**Angelic Wellness**  
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863-293-7789  
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