PATIENT APPLICATION FOR TREATMENT

Last name:	First:		MI:	Gender ☐ M ☐ F	
Email:		Date of Birth:		Age:	
Your address:		City:		State:	
Zip:	SS#:	Home #	Cell #		
Prior Occupation:		Present Occupation:		Wk #	
Marital status? Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) ☐					
Emergency Contact?		Emergency Phone #			
How many children do you have? What are their ages?					
Have you ever had chiropractic care? ☐ Yes ☐ No How long has it been?					
Has anyone else in your family ever had chiropractic care? ☐ Yes ☐ No					
Do you smoke: ☐ Yes ☐ No How much?		Do you exercise: ☐ Yes ☐ No How much?			
What is the purpose or reason for this appointment?					
When do you notice it most? ☐ AM ☐ PM		Have you ever had this in the past? ☐ Yes ☐ No			
What makes it feel better?		What makes it feel worse?			
(Females only) Are you pregnant? ☐ Yes ☐ No					

Using the scale below, indicate the **severity** of your **main complaint** (when at its worst)

None		**Slight**		**Mild**		**Moderate**			**Severe**
1	2	3	4	5	6	7	8	9	10

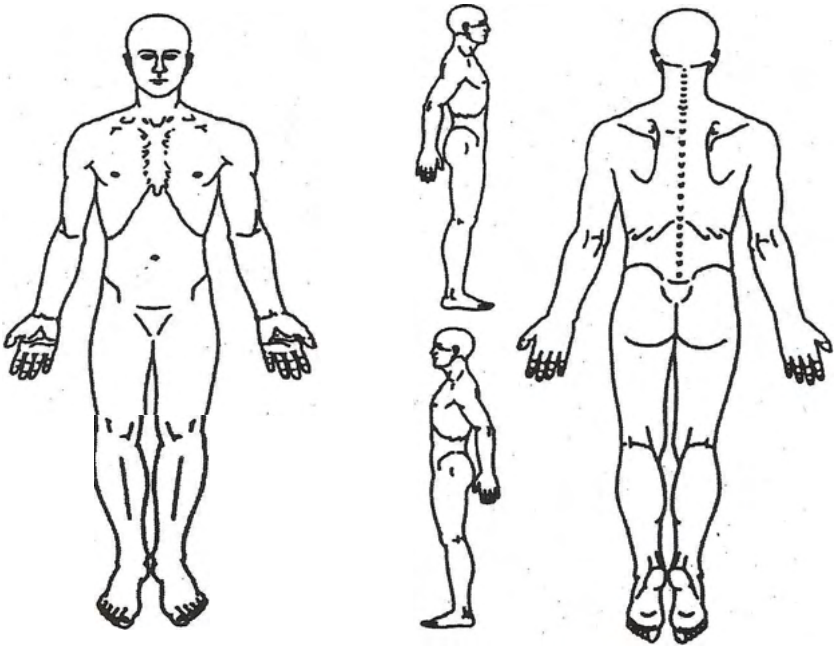
Using the scale below, indicate the **percentage of time** you experience your **main complaint**:

		Occasional		**Intermittent**		**FREQUENT**			**CONSTANT**	
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

How long have you been experiencing your **main complaint**?

On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ACHE **B:** BURNING PAIN **C:** CRAMPING **D:** DULL PAIN **R:** THROBBING PAIN **N:** NUMBNESS **T:** TINGLING



Wellness 1st Integrative Medical Center, LLC

Initial Consultation/ Wellness Evaluation (Please Be Honest & Fill Out Completely)

Name: _____ Age: _____ Date: _____

Main Complaints/ Unwanted Health Problems:

1) _____ 2) _____

3) _____ 4) _____

How long have you been suffering with this/these problem/s?: _____

Any other complaints/ issues: _____

_____

Would you like improvement with any of the following?:

☐ Digestion: Reflux, Gas, Constipation, Diarrhea ☐ Sense of Well Being

☐ Sleep: Falling asleep or staying asleep ☐ Energy ☐ Mental Clarity, Memory

What have you tried doing to resolve this problem that Did Not work?

_____

Have you become discouraged or stressed about handling this problem?

_____

When your problem is at its worst, how does it make you feel?

_____

How does this problem interfere with the following areas in your life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

When it's at its worst, how much older does this make you feel? _____

Do you know how this/these problem/s may have started?

_____

What effect does this have on your body functions? _____

_____

Are you here visiting us to:

a) Resolve my immediate problem b) Lifestyle program for optimized living c) Both

d) Other: _____

How have you taken care of your health in the past?

Medications	Holistic
Routine medical	Vitamins
Exercise	Chiropractic
Diet and Nutrition	Other: _____

How did the previous methods work for you? _____

What are you afraid this might affect if no change is made?

☐ Job ☐ Marriage ☐ Freedom ☐ Future Abilities ☐ Kids
☐ Finances ☐ Time ☐ Relationships ☐ Life ☐ Sleep

What health conditions you are afraid this might turn into? Please Circle
☐ Arthritis ☐ Cancer ☐ Depression ☐ Diabetes ☐ Diminished Future Abilities
☐ Heart disease ☐ Surgery ☐ Stress ☐ Weight gain Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is NOT taken care of? Please be specific
_____
_____

What would be different or better without this problem? Please Circle:
☐ Confidence ☐ Family ☐ Diminished stress ☐ Healthy ☐ Self-esteem
☐ Outlook ☐ Work ☐ More Energy ☐ Sleep

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)
_____
_____
_____

Are there potential barriers that would prevent these goals from happening?
_____
_____

How can we eliminate or prevent these potential barriers?
_____
_____

What strengths do you have that will enable you to accomplish your goals?
_____
_____

How long have you been thinking about eliminating these health condition/s? ___days ____months ____years

On a scale of 1-10:
_____ How important is it for you to resolve your health concerns?
_____ Do you feel that you are coachable and would enjoy a mentor in helping you?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?
_____ Are you ready to get started today?

Do you believe your health condition/s: Check One
_____ Have been going on for too long & may require a lot/ some work?
_____ Have been going on for a short time & may require a little work?
_____ Have just come about and may require minor work?
_____ I'm happy with my health condition and it doesn't need any work?

Thank You & God Bless!

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3

Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome? **Yes** **No**

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3

Have you had your gallbladder removed? **Yes** **No**

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes			No
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

NEUROLOGICAL ASSESSMENT FORM

NAME: _____ **DATE:**_____

1. Are you left or right handed?……Right Left
2. Have you had a head injury?…… Yes No
3. Do you currently experience or have a past history of vertigo or balance disorders?……..… Yes No
4. Do you have any ringing or pressure in your ears? …….. Yes No
5. Do you experience nausea? …… Yes No
6. Do you find that your balance is getting worse? …… Yes No
7. Do you have difficulties walking down stairs?……..… Yes No
8. Do you find yourself searching for words frequently when you speak?……..… Yes No
9. Have you noticed your ability to concentrate is getting worse? ..……..…… Yes No
10. Do you get lost often or have a hard time with directions?……..…. Yes No
11. Do quick flashes of light on TV or loud noises bother you? ……..…… Yes No
12. Do you feel like you need to wear sunglasses outside?…… Yes No
13. Has your handwriting changed in recent years? …… Yes No
14. Do you have a hard time swallowing? …… Yes No
15. Do to gag easily?…… Yes No
16. Do you experience blurriness in you vision or have double vision? ……... Yes No
    - CIRCLE ALL THAT APPLY: Blurriness, Double Vision
17. Do you have any changes in smell or smell foul things that are not present?……... Yes No
18. Do you have any difficulty with taste or taste things differently than what you are eating? …… Yes No
19. Have you noticed clumsiness in hand coordination? …… Yes No
    - Which hand? CIRCLE: Right, Left
20. Do you have difficulty with short-term memory? …… Yes No
21. Have you been told you have or noticed any memory loss of past events?…….. Yes No
22. Have you noticed uneven sweating or temperature on one side of your body?…… Yes No
23. Do you have any tightness, weakness or instability in your back or neck?…… Yes No
    - CIRCLE ALL THAT APPLY: Back, Neck
24. Do you have tightness or feelings of weakness in you arms/hands or legs/feet?…… Yes No
    - CIRCLE ALL THAT APPLY: Arms/hands, Legs/feet
25. Do you ever have any numbness or tingling in your arms/hands, legs/feet or face?…….... Yes No
    - CIRCLE ALL THAT APPLY: Arms/hands, Legs/feet, Face
26. Do you have any difficulty with falling asleep or staying asleep?…… Yes No
    - CIRCLE ALL THAT APPLY: Falling asleep, Staying asleep
27. Do you get motion sickness easily (car sick or sea sick)? ……... Yes No
28. Do you ever experience flashes of light in you visual fields?…… Yes No
29. Do you ever experience dry eyes or mouth?…….. Yes No
    - CIRCLE ALL THAT APPLY: Eyes, Mouth
30. Do you ever experience increased tearing or salivation?…… Yes No
    - CIRCLE ALL THAT APPLY: Tearing, Salivation
31. Do you ever have slurred speech?……... Yes No
32. Have you noticed any drooping of your eyelids or facial muscles?…… Yes No
    - CIRCLE ALL THAT APPLY: Eyelids, Facial Muscles
33. Do you ever notice increased heart rate or pulse during the day? …… Yes No
34. Have you ever experienced or been diagnosed with arrhythmia (fluctuating heart rate)? …… Yes No
35. Do you experience Deja Vu? …… Yes No
36. Does driving cause you fatigue, headaches or any other symptoms?…… Yes No
    - CIRCLE ALL THAT APPLY: Fatigue, Headaches, Other Symptoms
37. Does working on a computer cause you fatigue, headaches or other symptoms? …… Yes No
    - CIRCLE ALL THAT APPLY: Fatigue, Headaches, Other Symptoms
38. Have you lost your interest in hobbies and functions you used to enjoy? …… Yes No
39. Do you have a hard time motivating yourself to engage in activities?…… Yes No
40. Do you ever have a fluttering of the eye or noticed you are blinking frequently? …… Yes No
41. Do you have difficulty distinguishing right and left?…… Yes No

Patient Signature:_____ **Date:** _____

Family Health History

Patient Name: _____ Date: _____

Please review the conditions listed below and indicate those tht are current health problems of yours or a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	You	Father	Mother	Spouse	Children			
	Age	Age	Age	Age	Age	Age	Age	Age
ADHD								
Allergies								
Anxiety								
Asthma								
Back troubles								
Bed wetting								
Cancer								
Colic								
Colitis								
Constipation								
Depression								
Diabetes								
Disc problems								
Ear infections								
Emotional Issues								
Emphyema								
Epilepsy								
Erectile Dysfunction								
Headaches								
Heart troubles								
Heartburns								
High Blood Pressure								
IBS								
Indigestion								
Infertility								
Insomnia								
Kidney trouble								
Neck pains								
Nervousness								
Obesity								
Pinched nerves								
Scoliosis								
Sinus troubles								
Skin problems								
Thyroid problems								
Other								

Additional comments: _____

_____