

# Health and Wellness Questionnaire

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Which # do you prefer to contact you? \_\_\_\_\_  
E-mail address: \_\_\_\_\_ (for in house use only)  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Marital Status: M W Separated D Single Spouses Name: \_\_\_\_\_ # of children: \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Primary Care Doctor \_\_\_\_\_ Chiropractor \_\_\_\_\_

Most patients are referred to our office by a caring family member or friend. What made you decided to visit our office? Friend/Family Member Name \_\_\_\_\_  
 Telephone Call  Sign  Website  Presentation  E-mail  Other \_\_\_\_\_

Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? \_\_\_\_\_ How many times have you had a massage? \_\_\_\_\_

Are you familiar with chiropractic?  YES  NO Are you familiar with massage therapy?  YES  NO

What are the reason(s) for your visit today? \_\_\_\_\_

Would you prefer (please circle one) temporary symptom relief or correction of the cause of the problem

How committed are you to getting well Not very – 1 2 3 4 5 6 7 8 9 10 – Very committed

Are you willing to follow a treatment program that is specifically designed for you to return to health?  
 YES  NO

Are you willing to take supplements?  YES  NO

Are you willing to make dietary changes?  YES  NO

Are you willing to start a moderate exercise program?  YES  NO

When was your last complete spinal examination including x-rays? \_\_\_\_\_  Never

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?  
Poor - 1 2 3 4 5 6 7 8 9 10 – Excellent

Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.  
Low – 1 2 3 4 5 6 7 8 9 10 – High

How do you relieve stress or pain? \_\_\_\_\_

Do you exercise?  Yes  No If yes, what frequency \_\_\_\_\_ Type of exercise \_\_\_\_\_

Are you currently experiencing any of the following conditions? (check all that apply)  
\_\_\_\_ Flu \_\_\_\_ Cold \_\_\_\_ Fever \_\_\_\_ Infection \_\_\_\_ Contagious Disease

Please list any health symptoms or health complaints you are experiencing and how long you have had these symptoms

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Please list any areas that you would like the doctor and/or massage therapist to pay particular attention to

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Please list any medications (vitamin, herbs, or pharmaceutical) taken now or at regular intervals (include explanation of what each medication is used to treat): \_\_\_\_\_  
 \_\_\_\_\_

Are you currently under the care of a physician?  YES  NO Whom? \_\_\_\_\_  
 Please list reason(s) \_\_\_\_\_

Are there any other health concerns you wish to discuss today?  YES  NO  
 If yes, please describe \_\_\_\_\_

Is there any chance you are pregnant?  YES  NO

Circle if you eat, drink, or use the following. To the right of the circle, write how many times a day/week

Antacids	Candy	Fried Foods
Aspirin	Soda	White Flour Products
Tylenol	Coffee	Luncheon Meats
Oral Contraceptives	Cigarettes	Margarine
Recreations Drugs	Distilled Water	Refined Sugars
Alcohol	Fast Food	Milk Products
Artificial Sweeteners	Non-Herbal Tea	Inhalers

Current Weight \_\_\_\_\_ Ideal Weight \_\_\_\_\_ Adult Maximum \_\_\_\_\_ Adult Minimum \_\_\_\_\_

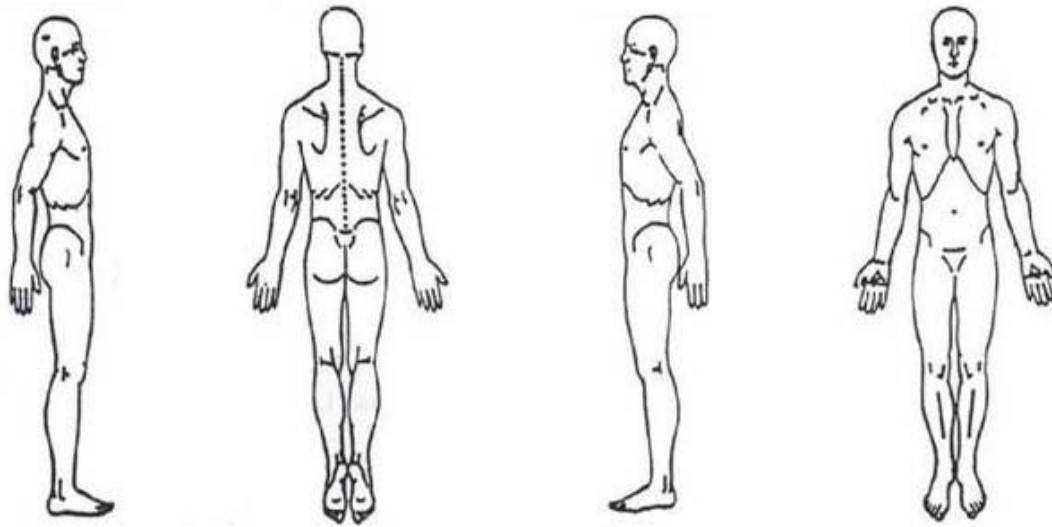
	Yes	No
Do you diet often?	<input type="checkbox"/>	<input type="checkbox"/>
Salt food without tasting?	<input type="checkbox"/>	<input type="checkbox"/>
Are you exposed to chemicals at work?	<input type="checkbox"/>	<input type="checkbox"/>
Are you exposed to cigarette smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sleep well?	<input type="checkbox"/>	<input type="checkbox"/>

Number of colds a year \_\_\_\_\_  
 Number of bowel movements a week \_\_\_\_\_  
 Number of earaches a year \_\_\_\_\_  
 Number of detoxification programs within the last year \_\_\_\_\_

Please review the list and check those conditions that have affected your health

<input type="checkbox"/> Accident	<input type="checkbox"/> Injury	<input type="checkbox"/> Decreased Range of Motion
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Whiplash	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Seizures	<input type="checkbox"/> Surgery
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Joint Ache	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Headaches	<input type="checkbox"/> Colitis	<input type="checkbox"/> Cancer
<input type="checkbox"/> Disk Problems	<input type="checkbox"/> TMJ Disorder	<input type="checkbox"/> Irregular Heart Beat
<input type="checkbox"/> Sprains	<input type="checkbox"/> Constipation/Diarrhea	<input type="checkbox"/> Auto-Immune Condition
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Skin Condition	<input type="checkbox"/> Depression
<input type="checkbox"/> Nervous Tension	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Blood Borne Disease
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke

Please circle any specific areas you have pain and/or would like the massage therapist to concentrate on



Are there any areas of your body you would prefer to be avoided? \_\_\_\_\_

Do you have a sensitivity/allergy to lotion or fragrance?  YES  NO

Are you wearing contact lenses?  YES  NO

Would you be interested in information on our massage and massage wellness membership programs?  
 YES  NO

If covered by your insurance, would you like more information on how to get massage therapy treatment at no additional charge to your chiropractic care if medically recommended?  YES  NO

Would you like to receive our weekly health and wellness newsletter via e-mail?  YES  NO

Would you be interested in an ionization detoxification foot bath for only \$10 as part of our wellness evaluation?  YES  NO

Consent for care:

It is my choice to receive massage therapy and I give consent to receive treatment. I understand that massage therapists DO NOT diagnose illness, disease, or any other physical or mental disorders. Massage therapy is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my massage therapist updated on my physical/mental health. I also agree there shall be no liability on the practitioners part shall I neglect to do so.

If I experience pain or discomfort during the session, I will immediately inform the practitioner so that he/she can adjust the pressure and technique being used.

If and when deemed necessary, I do hereby consent to x-ray examination and attest that if I am female I will notify the above mentioned if I believe that I could be pregnant so that proper precautions may be taken.

Patient Signature \_\_\_\_\_

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

Signature of Parent/Guardian \_\_\_\_\_  
(if patient is a minor)

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