Point Family
Wellness and Chiropractic

Welcome to Point Family Wellness and Chiropractic! We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

Patient General Information

(Please Print in Black or Blue Ink) Today's Date:____/____/____

Name: (First, MI, Last)____ Date of Birth:____/____/____

Home Phone: ____ Mobile Phone:____ Other Phone:____

Gender: ☐ Male ☐ Female Email:____ Contact Method *(check one)* ☐ H ☐ M ☐ O ☐ E@

SSN:____-____-____ Race: ☐ White ☐ Black/African American ☐ Hispanic ☐ Other____

Marital Status: ☐ Single ☐ Married ☐ Other Preferred Language: ☐ English ☐ Other____

Address:____ City, State, Zip:____

Occupation:____ Employer:____

Spouse's Name:____ Spouse's Occupation:____ Spouse's Employer:____

Names and Ages of Children:____

Emergency Contact:____ Relationship:____ Phone:____

How were you referred:____ Appointment Reminders: ☐ Email ☐ Text

Have you seen a Chiropractor before: ☐ Yes ☐ No *(If yes, who?)* ____

Insurance Information

☐ Insurance ☐ Cash

Insurance Company:____ Policy Number:____ Group Number:____

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian Policy Holder's Name:____

Policy Holder's Gender: ☐ Male ☐ Female Policy Holder's Date of Birth:____/____/____

Policy Holder's Address:____ City, State, Zip:____

History of Present Illness

Date of injury:____ Date Symptoms Appeared:____

What are your current complaints:____

How did your problem begin:____ ☐ Suddenly ☐ Gradual ☐ Post Injury

Have you ever had the same condition: ☐Yes ☐ No Have you seen another provider for this condition: ☐ Yes ☐ No

Since the condition began are the symptoms:

☐ Increasing ☐ Decreasing ☐ Not changing

What percent of the day are symptoms felt:

☐ 0 – 25 ☐ 25 – 50 ☐ 50 – 75 ☐ 75 – 100

What makes your symptoms better:

____

What makes your symptoms worse:

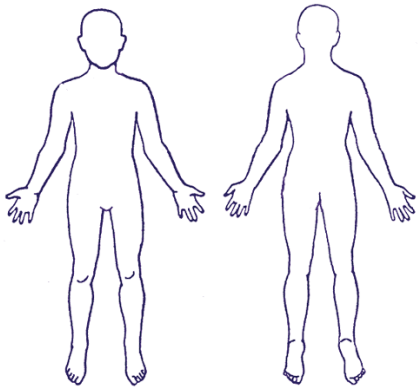
____

Rate the severity of your pain: *(0 = No Pain, 10 = A lot of Pain)*

0 1 2 3 4 5 6 7 8 9 10

Mark the areas on this body where you feel the described sensations. Please use the appropriate symbols .

))))))	Aching
xxxx	Burning
oooo	Dull
: : : :	Sharp
/////	Stabbing
++++	Throbbing
*****	Numbness/Tingling



Social History

What are your hobbies:_____

Do you use tobacco products: ☐ Yes ☐ Former smoker ☐ Never been a smoker If yes, how many packs per day:_____

If you are a former smoker, how long has it been since quitting:_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often?_____

Do you exercise: ☐ Yes ☐ No If yes, in what way:_____

Medical History

Please list any Hospitalizations, Auto Accidents, Surgeries, Serious Illness, or Serious Injuries:

Date:_____Briefly Explain:_____

Date:_____Briefly Explain:_____

Please list any known allergies:_____

Current Medications and Supplements: *(Please include prescription and over the counter medications)*

Medication	Reason	Supplements

Family Health History

Please indicate if a family member (parent, sibling, or child) has had or currently has any of the following conditions:

☐Arthritis ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ Cancer

If deceased, please list cause of death:_____

Medical Conditions

Please indicate if you've had or presently have any of the following conditions: ☐ Acid Reflux ☐ ADD/ADHD ☐ Allergies

☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Cancer ☐ COPD ☐ Constipation ☐ Depression ☐ Diabetes

☐ Headaches ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Liver Disease ☐ Osteoporosis ☐ Renal Disease

☐ Seizure ☐ Stroke ☐ Thyroid Disease ☐ Ulcers ☐ Other_____

Health Goals

What are your top three health goals:

1._____2. _____3._____

What would you like to gain from chiropractic care? ☐ Resolve existing condition ☐ Overall wellness ☐ Both

Do you have any health concerns for other family members today?_____

Are you open to other therapies to help improve your care? ☐ Acupuncture ☐ Massage ☐ Nutrition

Signature

I certify this information is true and correct to the best of my knowledge. I will notify Point Family Wellness and Chiropractic of any changes in my status or the above information. I consent to a chiropractic evaluation and treatment by the doctor.
I understand that any fee for service rendered is due at the time of service.

Patient Signature:_____Date:_____

Guardian Signature:_____Date:_____

Physician Signature:_____Date:_____

Vitals (OFFICE USE ONLY)

Height:_____Weight:_____ Pulse:_____ Resp:_____Temp:_____BP:_____/_____BMI:_____

SYSTEMS SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ☐ Female ☐

Pulse: Recumbent _____ Standing _____ Vegetarian ☐ Gluten-free ☐

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ☐

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurs rarely).
○ ● ○ MODERATE symptoms (occurs several times a month).
○ ○ ● SEVERE symptoms (occurs almost constantly)
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	
				GROUP 1
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Cut heals slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold, clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Fever easily raised
18	○	○	○	Neuralgia-like pains
19	○	○	○	Staring, blinks little
20	○	○	○	Sour stomach often
				GROUP 2
21	○	○	○	Joint stiffness on arising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen, puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; feels "lightheaded" often
29	○	○	○	Digestion rapid
30	○	○	○	Vomiting frequent
31	○	○	○	Hoarseness frequent
32	○	○	○	Breathing irregular
33	○	○	○	Pulse slow; feels "irregular"
34	○	○	○	Gagging reflex slow
35	○	○	○	Difficulty swallowing
36	○	○	○	Constipation, diarrhea alternating
37	○	○	○	"Slow starter"
38	○	○	○	Get "chilled" infrequently
39	○	○	○	Perspire easily
40	○	○	○	Circulation poor, sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				GROUP 3
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetite
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Fatigue, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Overeating sweets upsets
52	○	○	○	Awaken after few hours sleep - hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression - "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				GROUP 4
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	High altitude discomfort
60	○	○	○	Opens windows in closed rooms
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon "yawner"
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles, worse at night
65	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily, "black and blue" spots
69	○	○	○	Tendency to anemia
70	○	○	○	"Nose bleeds" frequent
71	○	○	○	Noises in head, or "ringing in ears"
72	○	○	○	Tension under the breastbone, or feeling of "tightness", worse on exertion
				GROUP 5
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter, metallic taste in mouth in mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Worrier, feels insecure
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upset
85	○	○	○	Stools light colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Use laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmare type bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				GROUP 6
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul-smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucous colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

	1	2	3	
				GROUP 7A
107	O	O	O	Insomnia
108	O	O	O	Nervousness
109	O	O	O	Can't gain weight
110	O	O	O	Intolerance to heat
111	O	O	O	Highly emotional
112	O	O	O	Flush easily
113	O	O	O	Night sweats
114	O	O	O	Thin, moist skin
115	O	O	O	Inward trembling
116	O	O	O	Heart palpitates
117	O	O	O	Increased appetite without weight gain
118	O	O	O	Pulse fast at rest
119	O	O	O	Eyelids and face twitch
120	O	O	O	Irritable and restless
121	O	O	O	Can't work under pressure
				GROUP 7B
122	O	O	O	Increase in weight
123	O	O	O	Decrease in appetite
124	O	O	O	Fatigue easily
125	O	O	O	Ringing in ears
126	O	O	O	Sleepy during day
127	O	O	O	Sensitive to cold
128	O	O	O	Dry or scaly skin
129	O	O	O	Constipation
130	O	O	O	Mental sluggishness
131	O	O	O	Hair coarse, falls out
132	O	O	O	Headaches upon arising, wear off during day
133	O	O	O	Slow pulse, below 65
134	O	O	O	Frequency of urination
135	O	O	O	Impaired hearing
136	O	O	O	Reduced initiative
				GROUP 7C
137	O	O	O	Failing memory
138	O	O	O	Low blood pressure
139	O	O	O	Increased sex drive
140	O	O	O	Headaches, "splitting or rending" type
141	O	O	O	Decreased sugar tolerance
				GROUP 7D
142	O	O	O	Abnormal thirst
143	O	O	O	Bloating of abdomen
144	O	O	O	Weight gain around hips or waist
145	O	O	O	Sex drive reduced or lacking
146	O	O	O	Tendency to ulcers, colitis
147	O	O	O	Increased sugar tolerance
148	O	O	O	Women: menstrual disorders
149	O	O	O	Young girls: lack of menstrual function
				GROUP 7E
150	O	O	O	Dizziness
151	O	O	O	Headaches
152	O	O	O	Hot flashes
153	O	O	O	Increased blood pressure
154	O	O	O	Hair growth on face or body (female)
155	O	O	O	Sugar in urine (not diabetes)
156	O	O	O	Masculine tendencies (female)
				GROUP 7F
157	O	O	O	Weakness, dizziness
158	O	O	O	Chronic fatigue
159	O	O	O	Low blood pressure
160	O	O	O	Nails weak, ridged
161	O	O	O	Tendency to hives
162	O	O	O	Arthritic tendencies
163	O	O	O	Perspiration increase
164	O	O	O	Bowel disorders
165	O	O	O	Poor circulation
166	O	O	O	Swollen ankles
167	O	O	O	Crave salt
168	O	O	O	Brown spots or bronzing of skin
169	O	O	O	Allergies - tendency to asthma

	1	2	3	
170	O	O	O	Weakness after colds, influenza
171	O	O	O	Exhaustion - muscular and nervous
172	O	O	O	Respiratory disorders
				GROUP 8
173	O	O	O	Muscle weakness
174	O	O	O	Lack of Stamina
175	O	O	O	Drowsiness after eating
176	O	O	O	Muscular soreness
177	O	O	O	Rapid heart beat
178	O	O	O	Hyper-irritable
179	O	O	O	Feeling of a band around your head
180	O	O	O	Melancholia (feeling of sadness)
181	O	O	O	Swelling of ankles
182	O	O	O	Diminished urination
183	O	O	O	Tendency to consume sweets or carbohydrates
184	O	O	O	Muscle spasms
185	O	O	O	Blurred vision
186	O	O	O	Loss of muscular control
187	O	O	O	Numbness
188	O	O	O	Night sweats
189	O	O	O	Rapid digestion
190	O	O	O	Sensitivity to noise
191	O	O	O	Redness of palms of hands and bottom of feet
192	O	O	O	Visible veins on chest and abdomen
193	O	O	O	Hemorrhoids
194	O	O	O	Apprehension (feeling that something bad will happen)
195	O	O	O	Nervousness causing loss of appetite
196	O	O	O	Nervousness with indigestion
197	O	O	O	Gastritis
198	O	O	O	Forgetfulness
199	O	O	O	Thinning hair
				FEMALE ONLY
200	O	O	O	Very easily fatigued
201	O	O	O	Premenstrual tension
202	O	O	O	Painful menses
203	O	O	O	Depressed feelings before menstruation
204	O	O	O	Menstruation excessive and prolonged
205	O	O	O	Painful breasts
206	O	O	O	Menstruate too frequently
207	O	O	O	Vaginal discharge
208			O	Hysterectomy / ovaries removed
209	O	O	O	Menopausal hot flashes
210	O	O	O	Menses scanty or missed
211	O	O	O	Acne, worse at menses
212	O	O	O	Depression of long standing
				MALE ONLY
213	O	O	O	Prostate trouble
214	O	O	O	Urination difficult or dribbling
215	O	O	O	Night urination frequent
216	O	O	O	Depression
217	O	O	O	Pain on inside of legs or heels
218	O	O	O	Feeling of incomplete bowel evacuation
219	O	O	O	Lack of energy
220	O	O	O	Migrating aches and pains
221	O	O	O	Tire too easily
222	O	O	O	Avoids activity
223	O	O	O	Leg nervousness at night
224	O	O	O	Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____