



THE WELLNESS PROS

ACTIVE & INTEGRATIVE CARE

Confidential Patient Information

Name _____ Sex M F DOB _____ Age _____ Date _____

Marital Status S M D W # of Children _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Phone (Cell/Other) _____

Occupation _____ Phone (Work) _____

Employer _____ Email Address _____

Spouse's Name _____ Spouse's Occupation _____

REFERRED BY: _____

Major Complaint Information I

Chief Complaint 1. _____ Duration (How Long) _____ Previous Episodes _____

Chief Complaint 2. _____ Duration (How Long) _____ Previous Episodes _____

Chief Complaint 3. _____ Duration (How Long) _____ Previous Episodes _____

Chief Complaint 4. _____ Duration (How Long) _____ Previous Episodes _____

Has this problem been getting worse or staying the same? _____

Are your present problems due to an injury? No Yes On Job Auto Accident Personal Other _____

Has the accident been reported? No Yes To Employer Auto Carrier Other _____

Have you retained an Attorney? No Yes Name & Address _____

Primary Physician _____ Address _____ Ph# _____

Past Chiropractic Care? No Yes When? _____ Results _____

Major Complaint Information II

Please mark the intensity of your pain today

1 - No Pain

10 - Most Intense Ever Felt

Example _____ Neck _____

1. _____ 1 2 3 4 5 6 7 8 9 10

2. _____ 1 2 3 4 5 6 7 8 9 10

3. _____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

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_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

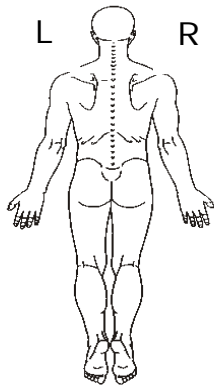
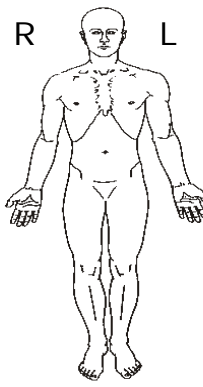
_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

Pain Index	
N	Numbness
T	Tingling
S	Soreness
P	Pain
A	Ache
ST	Stiffness
For example: if you are experiencing moderately severe burning pain in the back of your neck, you should note a B on the neck of the illustration and mark a 8 on the chart to the left.	



Have you had any surgeries or hospitalizations? Yes No If yes, please list: _____

Please list any current or past injuries and illnesses not listed above: _____

Please list all medications (prescriptions or non-prescriptions) you are currently taking: Aspirin/Tylenol

Pain killers Muscle Relaxers Insulin Tranquilizers Birth Control Pills Allergy Relief

Others _____

Patient's Signature _____ Date _____