

Welcome to The Wellness Center

APPLICATION FOR CARE: We have helped thousands of individuals achieve their highest level of health through our Wellness Programs. Our Brain-Based Therapy (BBT) is very unique and we expect our patients to achieve miraculous results. Please fill out this form to the best of your ability. This information will be reviewed by your doctor to determine if you will be accepted for care in our office. Please feel free to ask any questions. We look forward to serving you.

Full Name _____ Age ____ DOB ____/____/____

Home Phone (____) _____ Cell (____) _____ E-mail _____

Home Address _____ City _____ State ____ Zip _____

Marital Status S M D W Name of Spouse/significant other _____

Occupation _____ Business Phone _____

Whom may we thank for referring you to our office? _____

Names and ages of children _____

Have you ever received Chiropractic care? Yes No With whom? _____

How often did you go? _____ Date of last visit: ____/____/____

What hobbies or activities do you enjoy? _____

Date of last medical consultation ____/____/____ Reason _____

For women: Are you pregnant? Yes No

Please list (in order of importance) the 3 main areas in your health that you would like to improve or change.

1 _____

2 _____

3 _____

ABOUT YOUR HEALTH HISTORY

Throughout life, stress and traumatic events can damage your spine and nerve system. This stress may be **PHYSICAL, CHEMICAL and/or EMOTIONAL**. The information below will help us better understand the stress that you have experienced. We will compare this information with your examination findings.

BIRTH TRAUMA

Research indicates that the birth process causes trauma to a baby's delicate spine and nerve system. Please circle (to the best of your recollection). Was your birth:

In a Hospital Drug induced C section Breech Natural Home Birth
Midwife Vacuum extraction Prolonged Umbilical cord around neck Forceps

GENERAL PHYSICAL TRAUMA:

Most traumas occur in the early years (between birth and early twenty's). During that time your spine and nerve system are growing and are more vulnerable to injury. Inactivity, such as sitting for long periods, also damages the spine.

Have you had accidents related to the following? (Circle all that apply and give dates)

Automobile Motorcycle Bicycle Sports Other: _____

If yes, please explain: _____

Have you **ever** injured your spine or nerve system? (Head, neck, back, pelvis, hips): Yes No

If yes, please explain: _____

Do you (or anyone else) crack your back or neck? Yes No

Have you **ever** broken any bones or sprained any part of your body? Yes No

If yes, please explain: _____

Have you **ever** had surgery or been hospitalized? Yes No

If yes, please explain: _____

How many times a week do you exercise? 0 1 2 3 4 5 6 7 (Please Circle)

How many **total** hours a day do you sit (work, TV, driving, school, etc.) _____

How many **total** hours a day are you on a cordless phone, cell phone or headset _____

HISTORY OF CHEMICAL STRESS

There are over 82,000 different man-made chemicals in our air, water and food. Chemical stress occurs due to these toxic substances that are inhaled, injected, taken orally, or absorbed into the skin.

Do you currently take? Prescription drugs Over-the-counter drugs Vitamins

Please list. _____

Have you previously been exposed to or are you currently exposed to? (please circle)

Tap water Smog Flu shots Chemicals Fumes Hair dye Smoke Cigarettes

How often do you consume? N=Never/Rarely D-Daily W=Weekly M=Monthly

Alcohol__ Coffee __ Tobacco__ Diet Soda __ Fast Food __ Candy __ Dairy__ Wheat__ Corn__

What is your blood type? _____ How much water do you drink daily? _____

HISTORY OF EMOTIONAL STRESS

Emotional stress creates tension in your spine and nerve system and causes the release of stress hormones in your body. Although it is common to be under stress, it can affect your overall health. Please circle the emotional stresses you have encountered.

Childhood trauma Yes No **Relationships** Yes No **Illness** Yes No

Loss of Loved One Yes No **Work/School** Yes No **Family** Yes No

Divorce/Separation Yes No **Financial** Yes No **Abuse** Yes No

QUALITY OF LIFE

How do you grade your physical health? Excellent Good Fair Poor

How do you grade your emotional health? Excellent Good Fair Poor

How do you grade your nutritional health? Excellent Good Fair Poor

How do you rate your **overall** "quality of life"? Excellent Good Fair Poor

Your Current Health

What is the **main reason** for your visit today? _____

How many hours per night do you sleep? _____ Do you dream? Y N How often _____

Please circle the stress-related symptoms you either have now or have had within the *past year*.

Back pain	Numbness	Fatigue	Hair loss
Neck pain	Cold hands/feet	Ears ring	Depression
Leg/knee/foot pain	Asthma	Chest pain	Nail fungus
Shoulder pain	Allergies	Food cravings	Catch colds easy
Elbow/wrist pain	Indigestion	Skin problems	Constipation
Headaches	Hot flashes	Earaches	Diarrhea
Dizziness	Hormone problems	Sinus problems	Arthritis
Insomnia	High blood pressure	Feeling old	Fainting
Frequent urination	Anger/Irritability	Palpitations	Increased sweating
Other _____			

What Type of Care are You Seeking?(Please circle)

Temporary relief only

Relief and optimum correction

Terms of Acceptance

The Wellness Center specializes in the detection, correction and prevention of stress-related disorders and imbalances of your brain-body connection. We do not treat or diagnose medical conditions nor dispense drugs. Today you will have a consultation and examination to evaluate the health of your spine and nerve system. The information gathered today will be analyzed. You will then be scheduled for a special visit with the doctor to discuss the results of your exam. If we accept your case, you will receive written recommendations outlining the steps needed to improve your health. Our methods include spinal adjustments, brain-based therapy, nutrition, detoxification, rehabilitative exercises, orthotics, and stress reduction. By signing below, you understand and agree to these terms.

Signature _____ Date ____/____/____

Signature of Parent (for minor): _____ Date ____/____/____