PATIENT APPLICATION

WELCOME to The Wellness Center of NY. We specialize in assisting our patients achieve their highest level of health through our spinal and postural corrective programs. Please fill out the following information thoroughly. Thank you.

Today's Date: _____

Name: _____ Prefer to be called: _____

Birth Date: _____ / _____ / _____ Age: _____ Gender: _____ Height: _____f _____in Weight: _____

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Marital Status: S M D W

Occupation: _____ Employer Name: _____

General Practitioner Name:_____ Phone Number:_____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: If you do not have symptoms describe what health changes you are here to achieve:

_____

_____

Is this related to an auto accident / work injury? ☐ Yes ☐ No If so, when: _____

When did this condition begin? _____/_____/_____ Did it begin: Gradual Sudden Progressive (over time)

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe: _____

Pain Scale: From 0 (no pain) to 10 (unable to move/bed ridden/horrible pain), where is your pain at today? _____

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the Pain Radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

Please list current medications: _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? □ Yes □ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? □ Yes □ No

Did you know posture determines your health? □ Yes □ No

Are you aware of any of your poor posture habits? □ Yes □ No

Explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening the body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? □ Yes □ No

LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE.

Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

The nervous system controls and coordinates all organs and structures of the human body. Misalignments or subluxations of spinal vertebrae and discs may cause irritation to the nervous system and affect the structure, organs and functions which may result in certain conditions.

Please check any of the following listed conditions that you have experienced in the past, or are currently experiencing (on next page)**:**

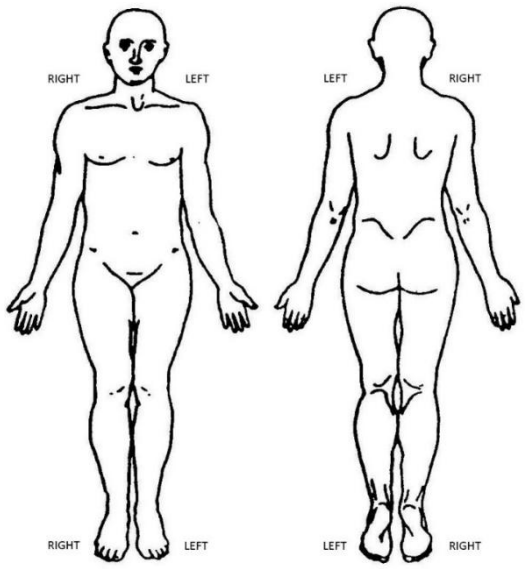
CERVICAL	Current	Past
Neck pain		
Headaches		
TMJ		
Hearing disturbances		
Thyroid conditions		
High blood pressure		
Numbness in arms/hands		
Pain in shoulders/arms/hands		
Recurrent colds/flu		
Dizziness		
Allergies/Hay fever		
Tingling in arms/hands		
Weakness in grip		
Visual disturbances		
Low energy/fatigue		

THORACIC	Current	Past
Midback/Shoulder blade pain		
Asthma/Wheezing		
Pain w/deep breath/expiration		
Nausea		
Indigestion/Heartburn/Reflux		
Tired/irritable without eating		
Recurrent lung infections/Bronchitis		
Shortness of breath		
Heart attack/Angina		
Pain in ribs/chest		
Hypoglycemia		
Family history of Diabetes		
Heart palpitations		
Ulcers/Gastritis		

LUMBAR	Current	Past
Low back pain		
Numbness in legs/feet		
Frequent/difficulty urinating		
Muscle cramps in legs/feet		
Injury in hip/knee/ankle		
Pain in hips/legs/feet		
Recurrent bladder infections		
Menstrual irregularities/cramping		
Tingling legs/feet		
Weak in legs/feet		
Sciatica		

Pain Diagram:

Please mark area(s) of health concerns:



The information provided above, and in this application, is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient Name: _____

Signature of Patient or Legal Guardian: _____ Date: _____