BLUE MOUNTAIN WELLNESS
ELEVATE YOUR HEALTH

Date _____ Birthday _____ Sex: ☐ Male ☐ Female

First Name _____ Middle Initial _____ Last Name _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Email: _____

Married/Civil Union: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

How did you find out about our office?: _____

Emergency Contact:

Emergency Contact Full Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Employment Information:

Employment: ☐ Full Time Employed ☐ Part Time Employed ☐ Full Time Student

☐ Part Time Student ☐ Retired ☐ Unemployed

Employer Name: _____ Occupation: _____

Employer Address: _____

_____

Purpose of Visit: ☐ Wellness ☐ Complaint ☐ Injury ☐ Other

Where did the injury occur?: _____ Date of Injury (if known): _____

Describe how the injury, pain, or discomfort originated: _____

Rate 1-10 (10 being the worst): _____ Describe your pain/discomfort: _____

Current Symptoms: _____

Select frequency you experience pain from this condition: ☐ Always ☐ Hourly ☐ Daily ☐ Occasionally

About Patient:

Does this condition interfere with any of your daily activities or routines? ☐ Yes ☐ No

Has this condition affected your appetite? ☐ Yes ☐ No

Have you missed any work due to this injury? ☐ Yes ☐ No

Have you reduced/limited your work hours due to this condition? ☐ Yes ☐ No

Is the pain/discomfort worse at certain times of the day? ☐ Yes ☐ No

Does the weather affect your pain/discomfort? ☐ Yes ☐ No

List anything that aggravates your condition: _____

Have you received professional treatment for this condition? ☐ Yes ☐ No

Have you had X-rays taken for this condition? ☐ Yes ☐ No

Have you ever had this same condition? ☐ Yes ☐ No

List other practitioners seen for this injury/condition: _____

Has this condition affected your quality of sleep? ☐ Yes ☐ No If yes, explain: _____

If yes, what dates have you missed work because of this? _____

List anything that relieves or improves your condition: _____

Please select all that you have had or currently have

☐ Allergies ☐ Alcoholism ☐ Anemia ☐ Arteriosclerosis ☐ Arthritis ☐ Asthma ☐ Back Pain

☐ Breas Lump ☐ Bronchitis ☐ Bruise Easily ☐ Cancer ☐ Chest Pain ☐ Cold Extremities ☐ Constipation

☐ Cramps ☐ Depression ☐ Diabetes ☐ Digestion Problem ☐ Dizziness ☐ Excessive Menstruation

☐ Eye Pain or Difficulties ☐ Fatigue ☐ Frequent Urination ☐ Headache ☐ Hemorhoids

☐ High Blood Pressure ☐ Hot Flashes ☐ Irregular Heart Beat ☐ Irregular Menstrual Cycle

☐ Kidney Infections ☐ Kidney Stones ☐ Loss of Memory ☐ Loss of Balance ☐ Loss of Smell

☐ Loss of Taste ☐ Nose Bleeds ☐ Pacemaker ☐ Polio ☐ Poor Posture ☐ Prostate Trouble ☐ Sciatica

☐ Shortness of Breath ☐ Sinus Infection ☐ Sleep Problems/Insomia ☐ Spinal Curvature ☐ Stroke

☐ Swelling of Ankles ☐ Swollen Joints ☐ Thyroid Condition ☐ Tuberculosis ☐ Ulcers

☐ Varicose Veins ☐ Veneral Disease ☐ Others_____

Medications & Allergy Information

Please list all medications and supplements you are currently taking, including dosage and frequency. Also list any known allergies and the type of reaction you experience.

Example: Metformin – twice daily; Lisinopril – once daily; Vitamin D – daily. Penicillin – rash; Peanuts – hives; Latex – skin irritation. If none, please write "None."

Social History and Life Choices:

Alcohol: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Water: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Tobacco: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Exercise: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Soft Drinks: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Drinks/Products: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Diet Food Products: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Medications: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Energy Products/ Over-the-Counter Stimulants: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Fresh & Homemade Foods: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Preprocessed, Packaged, & Restaurant Food: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

For Women Only:

Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Do you experience painful periods? ☐ Yes ☐ No Do you have irregular cycles? ☐ Yes ☐ No

Do you have breast implants? ☐ Yes ☐ No

Personal Incident History:

Broken bones? ☐ Yes ☐ No If yes, briefly explain: _____

Been hospitalized? ☐ Yes ☐ No If yes, briefly explain: _____

Past Surgeries? ☐ Yes ☐ No If yes, briefly explain: _____

Stroke? ☐ Yes ☐ No If yes, briefly explain: _____

Struck unconscious? ☐ Yes ☐ No If yes, briefly explain: _____

Major sprains/strains? ☐ Yes ☐ No If yes, briefly explain: _____

Family Health History:

Please list diagnosed health conditions and untimely death (condition, relationship to you).
(Family members include: Parents and siblings and maternal and paternal grandparents/aunts/uncles)

(Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.)

Goals for Your Care:

Please list what you would like to be able to do after treatment that you cannot currently do because of your condition:

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

☐ I agree with this statement of authorization

Signature _____ Date _____