Welcome to the Uptown Wellness Center

Requested Treatment: [ ]Massage/Hot Stone Therapy [ ]Spinal Decompression [ ]Acupuncture [ ]Chiropractic

Please provide us with all of the following:
Health Insurance cards • Drivers License • Auto/Work Injury Papers • Insurance/Attorney info
PRINT CLEARLY - All information is required & kept confidential.

Who referred you to our Center ? **Print Full Name of Patient, Doctor, Website, Directory or Event**

☐Referred by* ☐Internet website* ☐Health Fair/Event* ☐Met Doctor* ☐Yellow Pages* ☐Drove by
*Name: ____________________

Patient Information

Patient's First & Last Name: ____________________
Date of Birth: __________ Gender: Male Female Marital Status: single married widowed divorced
Address: __________ Apt/Suite#: ____ City: __________ State: ___ Zip: ______
Home Phone #: ( ) __________ Cell/Pager/Other #: ( ) __________
Email address: ____________________
Social Security #: __________ Driver's License #: __________

Emergency Contact Name: __________ Tel #: ( ) __________
Relationship to Patient: ____________________
Address: __________ Apt/Suite#: ____ City: __________ State: ____ Zip: ______
Home Phone #: ( ) __________ Cell/Pager/Other #: ( ) __________
Work Phone #: ( ) __________ Extension: ______ Email: __________

Patient Employment Information

☐ Not employed ☐ Self-employed ☐ Student ☐ Other: __________
Employer/School: __________ Occupation: __________
Address: __________ Apt/Suite#: ____ City: __________ State: ____ Zip: ______
Work Phone #: ( ) __________ Extension: ______

Patient Health Insurance Information

Do you currently have Health Insurance? ☐ No → **Discounted Wellness Plans available**
☐ Yes → Complete below

Name of Insured/Subscriber: ____________________
Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Legal Guardian ☐ Other: __________
Insurance Company name: ____________________
Plan Type: ☐ PPO ☐ HMO ☐ Medicare ☐ Other: __________
ID #: __________ Policy #: __________ Group #: __________
Insurance Tel # (on back of card): ( ) __________
Name of Primary Care Doctor: __________ Tel #: ( ) __________

Individual responsible for patient's account

☐ **Above patient is responsible** - OR - **First & Last Name:** ____________________
Relationship to patient: __________ Date of Birth: __________
Address: __________ Apt/Suite#: ____ City: __________ State: ____ Zip: ______
Home Phone #: ( ) __________ Cell/Pager/Other #: ( ) __________
Work Phone #: ( ) __________ Extension: ______
Email address: ____________________
Social Security #: __________ Driver's License #: __________

Patient Current Health Concerns

What is the primary purpose of your visit?
☐ Injury Care ☐ Temporary Relief Care ☐ Preventative/Correction Care ☐ Wellness Care

Did you injure yourself recently? ☐No ☐Yes→ **How?** ☐Auto Accident ☐Work Injury ☐Other:
When did you injure yourself? Date: ____________________
Are you currently receiving treatment for this injury? ☐ No ☐ Yes→ ____________________

What are your health goals? [check ALL that apply]
☐ Reduce/eliminate pain ☐ Reduce stress/tension ☐ Manage weight ☐ Manage diet/nutrition
☐ Increase strength/flexibility ☐ Increase energy/immunity ☐ Keep healthy/well
☐ Other Goals [e.g. sports/hobbies/activities]: ____________________

Which services & products may you be interested in?
☐ Spinal Decompression Therapy ☐ Laser Light Therapy ☐ Massage Therapy ☐ X-Rays ☐ Pillows
☐ Acupuncture ☐ Chiropractic ☐ Physiotherapy ☐ Vitamins/Herbs ☐ Foot arch supports

Where are your areas of concern? [Check ALL that apply and CIRCLE: R=RIGHT, L=LEFT]
Note how severe each area is on a scale of 0 (no pain) to 10 (extreme pain).

☐Headache:__/10
☐Jaw pain:__/10
☐Neck pain:__/10
☐Upper back pain:__/10
☐Mid-back pain:__/10
☐Low back pain:__/10
☐Chest:__/10
☐Abdomen:__/10

☐R/L Shoulder:__/10
☐R/L Elbow:__/10
☐R/L Wrist:__/10
☐R/L Hand:__/10
☐R/L Upper Arm:__/10
☐R/L Forearm:__/10

☐R/L Thigh:__/10
☐R/L Hip:__/10
☐R/L Knee:__/10
☐R/L Foot:__/10
☐R/L Ankle:__/10
☐R/L Upper leg:__/10
☐R/L Lower leg:__/10

☐ Other: ____________________

What makes your condition worse? ☐sitting ☐standing ☐walking ☐bending forward ☐lying down
☐ Other: ____________________

What makes your condition better? ☐ ice pack ☐ hot shower ☐ rest ☐ medications→__________
☐ Other: ____________________

Is your condition becoming progressively worse? ☐ No ☐ Yes→ Details: ____________________

____

Have you previously received treatment for this condition? ☐ No ☐ Yes→ **Check all that apply:**
☐ Surgery ☐ Medications ☐ Injections ☐ Chiropractic ☐ Physical therapy ☐ Acupuncture
☐ Other treatment: ____________________

Describe the quality of your pain/condition: ☐ sharp ☐ dull ☐ achy ☐ burning ☐ throbbing
☐ Other quality: ____________________

What percent of the day do you have your pain / condition?
☐ constant [100%] ☐ frequent [75%] ☐ intermittent [50%] ☐ occasional [25%]

How long have you had this condition? Since [month/day/year]: ____________________
hours: ____ # days: ____ # weeks: ____ # months: ____ # years: ____

Does your pain travel/radiate to another area of your body?
☐ No ☐ Yes→body region: ____________________

Has your condition interfered with your: ☐daily activities ☐work ☐house chores ☐sports
☐ Other: ____________________

Any other problems associated with your condition? ☐ No ☐ Yes→ ____________________

____

____

Patient Medical History & Information

Current Age: ______ Height: feet=____ inches=____ Weight: ______pounds
Date of Last Medical Exam: ____________ Medical Doctor's Name: ____________________________
Results of most recent...X-rays/CT/MRI: ____________________________
Blood/Lab Tests: ____________________________
Other Test Results/Findings: ____________________________

All Prescribed Medications:____________________________
All Over-The-Counter Medications: ____________________________
Do you have any congenital (from birth) factors which relate to your condition?
☐ No ☐ Yes→details/date: ____________________________
Do you have any previous illnesses/complications from previous injuries?
☐ No ☐ Yes→details: ____________________________
Have you ever been to the hospital for any reason (surgery, trauma, childhood, etc.)?
☐No ☐ Yes→details/date:____________________________
For Women: Is there any chance you may be pregnant: ☐ No ☐ Yes→# weeks: ______________

Check the following that apply to you:

Yes No
☐ ☐ Loss of consciousness/head injuries
☐ ☐ Seizures/Epilepsy/Convulsions
☐ ☐ Dizziness/Fainting
☐ ☐ Visual disturbances/Eye problems
☐ ☐ Nose, throat, breathing problems
☐ ☐ Asthma, allergies, allergic reactions
☐ ☐ Diarrhea, constipation
☐ ☐ Numbness in groin/buttocks/legs/feet
☐ ☐ Abnormal/rapid weight gain/loss
☐ ☐ High blood pressure
☐ ☐ Artificial joints
☐ ☐ Night sweats
☐ ☐ Pain at night
☐ ☐ Pain unrelieved by position/rest
☐ ☐ Morning pain/stiffness
☐ ☐ Cancer/tumor/lumps:______________

Yes No
☐ ☐ Lupus
☐ ☐ Diabetes
☐ ☐ Pacemaker
☐ ☐ Hernia
☐ ☐ Osteoporosis
☐ ☐ Sleep apnea/sleep conditions
☐ ☐ Menstrual problems
☐ ☐ Urinary Bladder control problems
☐ ☐ Recent fever
☐ ☐ Corticosteroid – cortisone, prednisone
☐ ☐ Birth control pills
☐ ☐ Pain killers/Muscle relaxants
☐ ☐ Alcohol/tobacco/drug abuse
☐ ☐ Rheumatoid arthritis
☐ ☐ Blood disease:______________
☐ ☐ Stroke – date:______________

Any Organ Problems/Diseases: ☐Heart ☐Liver ☐Kidney ☐Stomach ☐Pancreas ☐Gall bladder ☐Lungs ☐Intestines ☐Prostate ☐Uterus ☐Ovaries ☐Thyroid ☐Other:______________

Social History – Check ALL that apply

Current Health Condition: ☐chronic illness ☐poor ☐fair ☐good ☐other:______________
Emotional Stress level: ☐high ☐medium ☐low ☐none ☐other: ______________
Daily work/home habits: ☐prolonged sitting ☐ prolonged standing ☐lifting heavy items ☐poor posture ☐extensive computer work ☐other:______________
Eating habits: ☐balanced ☐fast food ☐vegetarian ☐high fat/carbs ☐other:______________
Sleeping habits: ☐on back ☐on side ☐on stomach ☐6-8 hours ☐other:______________
Daily Exercise: ☐walk ☐jog/run ☐lift weights ☐stretch/yoga ☐other______________
Sports/Acitivites/Hobbies:______________
Daily Nutrition Supplements/Vitamins: ☐multi ☐none ☐other→______________
Do you wear: ☐custom foot orthotics ☐arch supports ☐heel lifts ☐none ☐other:______________

Family Medical History

Family Member Names	Age	Health Status / Conditions / Concerns [neck, back/disc pain, growing pains, arthritis/joint pain, cancer, etc]
Father:		☐none
Mother:		☐none
Brother(s): Sister(s):		☐none
Spouse:		☐none
Children:		☐none