New Braunfels Family Wellness Center

1135 West Mill Street New Braunfels TX, 78130
Office: (830)625-9255 Fax: (830)643-9255
NewBraunfelsWellness.com

PATIENT INFORMATION

DATE:_____

Legal Name:_____ Nickname:_____
Address: _____
City:_____State:_____Zip Code: _____
Date of Birth: _____ Age:_____SSN: _____
Cell #: _____Work #: _____ Home #: _____
Occupation: _____ Employer: _____
E-mail Address: _____
Marital Status: Married Single Widow Divorced Separated
Spouse Name:_____
If you have children, please list their name and age:_____
How did you hear about our office? [] Referred [] Website [] Other_____
If referred, **by whom**? _____

Please check reasons for pursuing chiropractic care:

[] I'm continuing ongoing care from another chiropractor. [] I'm interested in Wellness and Natural health care.
[] I'm concerned about my health and I'm looking for answers. [] I have a specific condition that concerns me.

HEALTH HISTORY

Please list your symptoms below in order of importance *and* give date symptoms began.

1._____ Date _____
2._____ Date _____
3._____ Date _____

Is this condition due to: [] Auto Accident [] Work Injury [] Other Accident [] Not Sure

1. Please describe what aggravates your symptom(s):

   _____

   Please describe what alleviates your symptom(s):

   _____

2. What is the nature of your symptom(s)?
   [] Sharp [] Dull Ache [] Burning [] Numb [] Tingling [] Throbbing

3. Does your symptom(s) radiate:
   [] Up [] Down [] Left [] Right [] Other_____

4. How often do you experience your symptom(s)?
   [] Constantly [] Frequently [] Occasionally [] Intermittently

5. Who have you seen for your symptom(s)?
   [] No One [] Medical Doctor [] Other Chiropractor [] Physical Therapist
   []Other_____

6. Have you experienced this symptom(s) before? [] YES [] NO
If yes, please tell us when it started and how often since then you have experienced it:
_____

7. What tests have you already had for your symptom(s)?
[] X-Rays []MRI [] CT Scan [] Lab Work [] None [] Other_____

8. Are you currently using any of the following:
[] Medications []Drugs []Tobacco []Alcohol []Vitamins/Minerals/Herbs
(IF YOU CHECKED ANY OF THESE PLEASE SEE NEXT PAGE TO LIST SPECIFICATIONS)

9. Physical Activity: [] Sitting 50% or more [] Light Labor [] Manual Labor
[] Heavy Labor [] Exercise [] Repeated Motion

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU:

[] HEADACHES/MIGRAINES	[] HIGH BLOOD PRESSURE	[] ALLERGIES	**FEMALES:** Are you pregnant?
[] ASTHMA	[] CHOLESTEROL ISSUES	[] DIZZINESS	[] YES [] NO
[] HIV/AIDS	[] HEPATITIS A, B, C	[] ACID REFLUX	

Please list below any surgeries you have had in the past:

Date of Surgery	What kind of surgery was it?	What was the reason for this surgery?

*If you have, or have had, any diseases please let us know what it is and when it presented itself:
_____

MEDICATIONS

Please list all medications/vitamins you are currently taking including over the counter drugs.
Also, list how long you have taken each drug and the condition for which it is taken.

Date of Started	Medication/Vitamin Name	What is it being taken for? Dosage and how often?

PRIMARY CARE PROVIDER
Do you have a primary care physician [] Yes [] No.
If yes, and your condition requires, we would like to keep your doctor informed about your condition and the care you receive at our office. If you have no objection to this, sign and date.
Primary Physician's Name: _____ City: _____
Phone Number: _____

PAST TRAUMAS

The vast majority of our population has been involved in dozens of impacts that could cause vertebral subluxation. We would like to discover some of yours.

Auto Accidents: *Please list any auto accidents beginning with the most recent.*

Date	Speed	Location of Impact	Any Treatment	Chiropractic Care?
		Rear, Side, Front	Yes No	Yes No
		Rear, Side, Front	Yes No	Yes No
		Rear, Side, Front	Yes No	Yes No

Slips, Falls, Strains, or Broken Bones: *Please list beginning with the most recent.*

Type of Trauma	Date	Describe	Any Treatment	Chiropractic Care?
Fall, Strain, Break			Yes No	Yes No
Fall, Strain, Break			Yes No	Yes No
Fall, Strain, Break			Yes No	Yes No

PEDIATRIC SECTION

(Age 11 and younger)

1. Adopted? [] YES [] NO
2. Complications during pregnancy? [] YES [] NO
   If yes, please describe: _____
3. Drugs/Cigarette/Alcohol during pregnancy? [] YES [] NO
4. Location of birth? [] Hospital [] Birthing Center [] Home [] Other_____
5. Check any that apply:
   - [] MOTHER INDUCED [] MOTHER MEDICATED
   - [] CAESARIAN SECTION [] FORCEPS
   - [] VACUUM EXTRACTED [] BABY GIVEN MEDICATION
   - [] NICU STAY REQUIRED [] ICU FOR MOTHER REQUIRED
6. Breastfed? [] YES [] NO
7. Any complications during delivery? [] YES [] NO
   If yes, please explain: _____

HOBBIES (past and present):_____

SPORTS (past and present):_____

GOAL QUESTION:
If you could accomplish one important thing or mission in your life, **what would it be?**

_____

_____

If chiropractic care works for you, what is something you would like to be able to do that you can't do, or have difficulty doing, now?

_____

_____

Please read the following statement. By signing below you acknowledge that you have read and understand your obligations, and have been made aware of your right to privacy (HIPAA) provided by this office. In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to New Braunfels Family Wellness Center.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, NOT between *New Braunfels Family Wellness Center* and my insurance company.

Furthermore, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payments. **Payment is due at time of service. *Thank you!***

I understand that the fee paid for x-rays is for analysis only. The film itself is the property of New Braunfels Family Wellness Center. Once films are used for treatment purposes, they cannot be released without proper written request, naming the physician who will have use of the films for two weeks.

_____ _____

Patient Signature Guardian/Spouse Signature

Date:_____

Thank you for taking the time to fill out this form as accurately as possible. This information is crucial to your case and the doctor will be reviewing it very carefully and correlating this information with your x-ray and exam findings.

We look forward to helping you and your family on the journey toward optimal health!