Center For Well Being
3601 Minnesota Drive
Suite 160
Edina, MN 55435

PLEASE FILL OUT COMPLETELY

Today's Date__________________ **Referred by:**__________________________________

Name:____ **Male:**____**Female:**____
First / Middle Initial / Last

Mailing Address:________________________________**City:**__________________________

State:______**Zip:**_________**Birthdate:**__________**Age:**______**Height:**_____**Weight:**_____

Home Phone:_________________________ **Work Phone:**__________________________

Cell Phone:___________________________ **E-Mail:**______________________________

Social Security #:______________________**Occupation:**___________________________

Marital Status:____**S** ____**M** ____**D** ____**W** **No: of children:**___________

Complaints Please rank your current complaints and rate their severity (on a scale of 1-10, 10 is severe)

____
____
____
____
____

Other information Please tell us any additional information that the doctor should know

____
____

Smoking: Do you currently smoke?_____If yes, how much?_______How long have you smoked?___________
Surgeries: What surgeries, operations, traumas, car accidents, etc. Have you had?

____
____

a) Do you have breast implants?_______Other surgical implants or prostheses?____________________
b) Have you had elective surgery (tummy tuck, face-lift, burned off moes, etc.)?____________________
c) Do you have any metal or plastic inside your body (such as pins, clamps, plates, etc.)?______________
d) Do you have pierced ears or other body piercings?_____________Tattoos?_________________

Current Medications:____
____

Current Vitamins/Minerals:____
____

Stress Please rate your current stress level *(on a scale of 1 to 10, 10 being the highest):* ________________
What is the main reason(s) for your stress? ________________
If over level 5, what step(s) are you taking to reduce your stress level? ________________

Dental work Indicate how many of the following you have:

Silver fillings ______ Gold crowns or inlays ____ Posts ____ Bad bite ____
Composites (tooth colored) ____ Stainless steel crowns/inlays ____ Implants ____ New cavities __
Extractions ____ Porcelain crowns/inlays ____ Braces ___
Bridgework ____ Veneers _____ Bleeding gums _____
Partial or full dentures _____ Root canals _____ Sensitive teeth _____

Do you need further dental work? ______ If so, what? ________________
Name of your dentist: ________________

Healthcare Recent Chiropractic Physician: name ________________ Last seen: ____________
Recent Medical Physician: name ________________ Last seen: ____________
Recent Laboratory tests done: ________________
Significant findings: ________________

Health Overview *For the following questions, circle the phrases that apply to you*

Sleep How is your sleep? (*restful, restless, hard to get to sleep, wake up often, get up during night, bad dreams)*
Other symptoms? ________________
What time do you usually go to sleep? ______________ Number of hours of sleep per night? ____
Type of mattress? *(box spring, water, air, futon)* Type and size of pillow? ________________
Type of sheets, covers, bedding? (*100% cotton, polyester, blend)* ________________

Digestion How is your digestion? *(adequate, poor, acid reflux or heartburn, burp often, bloated, nausea, vomiting, abdominal pain - high or low)*
Other symptoms? ________________

Urination How are your daily urinations? *(every 2-3 hours, too frequent, sense of urgency, too small amount too large amount, burning, dribbling, up at night several times, discolored urine)*
Other symptoms? ________________

Bowels How are your bowel eliminations? *(How often? 3/2/1 times daily, skip days Amount: normal, too little, too large Consistency: normal, too hard, very soft, diarrhea Color: brown, black, whitish or green Other: lots of mucus, lots of gas, foul smell, do they sink or float?)* Hemorrhoids? ______
Other symptoms? ________________

Women Only: Are you pregnant? _____ Are you breast-feeding? _____ Do you have monthly periods? ___
Date of last menstrual period? ________ In menopause? ____ Have your periods stopped? ______
Had a hysterectomy? ______ If so, when? ____________
Are your monthly periods regular (28 day cycle)? ________ Number of days of flow? __________
Circle any of the following symptoms you experience associated with your period: cramping, bloating, feeling weak, mood swings, cravings, heavy bleeding, back pain, headaches, bright red blood, dark clotty blood. Other menstrual symptoms? ________________
Have you had a recent pap smear? ____ Mammogram? ________ Pelvic exam? ____________
Do you take oral contraceptives? _____ If so, what type? ________________
Do you take hormone replacements? ______ If so, what type? ________________
Any additional symptoms or relevant information? ________________

Pain **Do you experience back pain? _____ Circle: Low back/mid back/upper back/rib cage area**
Do you experience neck pain? ____ Circle: Stiff, dull, ache, sharp, spasms
Do you experience headaches? ____ Circle: front of head, sides, temples, top, back *How often?*____
Do you have leg pains? ______ Circle: thigh/knee/calves, feet Numbness? ________
Do you have arm pains? _____Circle: upper arm, forearm, wrist, hand Numbness? _______
Do you take pain medication? ____ If so, what type and how much? ____________________________
Do you have other pain locations? ____ Where? ____
Have you had any other treatment of anything noted above? ____ If so, what? __________________
____

Cardiovascular ***Circle*****: Fainting episodes, dizziness, blurred vision, rapid heart rate, skipped heart beats, chest constriction/pain, varicose veins, swollen feet/ankles, spider veins, high blood pressure, low blood pressure, shortness of breath, leg pains after exercise or rest. Other: ________________**
Current medications for any of these: **____**

Brain/ Cognition ***Circle:*** **Confusion, lack of concentration, spaciness, poor memory, "brain-fog", mood changes, agitated/anxiety, depression, Parkinson's, early onset dementia**
Any other problems, or diagnosed issues? ____
Current medications for any of these? **____**

Respiratory ***Circle:*** **Frequent colds, flu Sinus infections Sinus drainage or sniffles Sneezing Allergies Clearing throat Coughs(dry/mucus) Sore throats Bronchitis Asthma Reactive airways**
Other: ____
Current medications for any of these? **____**

Energy Levels **How do you feel your energy level is? ____**
Diagnosed with chronic fatigue syndrome? _____Do you feel refreshed from sleep? _______

Diseases you have had ***(Circle)***
Anemia, Arthritis, Bronchitis, Cancer, Chicken pox, Colitis, Crohn's, Diabetes, Eczema, Heart disease, Influenza, Measles, Pleurisy, Pneumonia, Polio, Rheumatic fever, Thyroid (low/high)
Other: ____

Exercise **What kind of exercise do you do? ____**
How often? ____________________ For how long a time? _____________________________

Eyewear **Do you wear contact lenses? _______ Glasses? ______ If so, how many hours a day? __________**
Do your lenses have tints? _______ An anti-glare coating? ______ A scratch resistant coating? ____

Electromagnetic Exposure **How many hours do you spend daily:**
Watching TV?___ Working on a computer?___Talking on a phone?____Talking on a cellular phone?___
Wearing a pager? ___ Wearing a headset? ___ Wearing a wrist-watch (with battery)? ___
Riding in a car/truck/vehicle?____ Near electrical equipment for long periods of time (such as copy machines, high power lines, computers, etc. ____ When you sleep, is your head within 10 feet of a plug-in clock (such as on a night stand)? _____

Clothing **How often do you wear 100% natural clothing (cotton, ramie, wool, silk, linen, etc.)? __________**
Synthetic clothing (polyester, acrylic, nylon, etc.)? ____________ Blends? ________________________

Personal Care Products **List the brand names that you use** ***(Please take time to complete this list.)***

Shampoo?____________________ Shave Cream?____________________
Cream rinse? ____________________ Deodorant? ____________________
Toothpaste? ____________________ Soap? ____________________
Hand body lotion? ____________________ Facial Cleanser/Moisturizer? ____________________
Hair spray/gel? ____________________ Personal (sexual) lubricant? ____________________
Hair dye? ____________________ Contraceptive jelly/spermacide? ____________________
Hair permanent? ____________________ Fingernail/Toenail polish? remover? ____________________
Face make-up? ____________________ Eye make-up? ____________________
Glass Cleaner? ____________________ Perfume/Cologne? ____________________
Dish washing soap?____________________ Laundry soap? ____________________
Tub/Tile Cleaner? ____________________ Oven Cleaner? ____________________
All Purpose Cleaner? ____________________ Roach/ant spray? ____________________
Toilet Freshener? ____________________ Carpet Cleaners? ____________________
Other chemical exposures *(from yard, workplace, art chemicals, etc.)*? ____________________

Appliances **Circle which of the following you use:**

Gas stove Electric stove Electric heater Electric blanket Water bed Microwave Juicer VitaMix
Air purifier *(Brand: ____________________)* Water Purifier *(Brand: ____________________)*

Cookware What type of cookware do you use? *Circle* Stainless steel, aluminum, iron, teflon-coated, glass, Corning, non-stick brands Other types: ____________________

Shower Filter Do you use a chlorine protection filter? _____ Brand: ____________________
When was your filter last changed? ____________________

Pets Do you have a pet(s)?_________ If so, what kind/how many? ____________________
Is it allowed in the house? ______ On your bed? ______ Do you use flea powders on the carpets? ___
What do you feed your pet(s)? ____________________

Family Health History

Next to the name of disease, denote F (father) M (mother) S (sister) B (brother) G (grandparent)

Alzheimer's ____ Arthritis ____ Asthma ____ Cancer ________ Diabetes ______
Depression ____ Epilepsy ____ Heart disease ________ High blood pressure ________
Liver disease _____ Parkinson's ______ Other: ____________________

Food Choices *Circle each type of food you eat often:*

1. Pre-made foods: a) canned food b) boxed cereals c) frozen dinners d) bottled/frozen juices e) take-out food
2. Red meat: (beef, pork, lamb) a) commercially grown b) organically raised
3. Chicken: a) commercially grown b) organically raised
4. Turkey: a) commercially grown b) organically raised
5. Fish: a) canned tuna b) fresh fish c) frozen fish d) at restaurants Favorites: ____________________
6. Fresh vegetables: a) commercially grown *(store-bought)* b) organically grown *(store-bought, self, farmer)*
7. Fresh fruit: a) commercially grown *(store-bought)* b) organically grown *(store-bought, self, farmer direct)*
8. Whole grains: a) commercially grown *(store-bought)* b) organically grown
9. Beans/Peas: a) commercially grown *(store-bought)* b) organically grown
10. Eggs/Butter: a) regular eggs b) organic eggs c) commercial or organic butter? d) Margarine use?____
11. Milk: a) commercial milk b) organic milk c) goat's milk
12. Cheese: a) commercial cheese b) organic cheese c) Feta or sheep cheese
13. Oils: a) commercial oils type: ______________ b) organic oils type: ____________________
14. Condiments: a) artificial sweeteners *(NutraSweet/Equal, Sweet'N low, Coffeemate, Saccharin, etc.)*
b) commercial salt and pepper c) sea salt d) commercial ketchup or mustard e) commercial vinegar
c) commercial mayonnaise, salad dressings

Food Stressors *Circle which of the following you have every week. Indicate how many times per week.*

Stimulants	Toxic Oils	Commercial Dairy	Highly heated foods
Coffee *(includ. decaff)*	Fried Foods	Cow's milk	Bread (store-bought)
Black tea	Fast food	Yogurt	Crackers (store-bought)
Soft drinks/pops	Potato/corn chips	Ice Cream	Bagels (store-bought)
Drinks w/NutraSweet	Roasted nuts	Cottage cheese	Buns (store-bought)
Alcohol	Mayonnaise	Sour cream	Pasta (store-bought)
Chocolate	Margarine	Cheese(regular)	Muffins (store-bought)
Candy, pastries, sweets	Peanut butter (commercial)		Cookies (store-bought)

Food Habits

1) Eating Out **Do you eat out at restaurants? ____ If yes, how often? ________ Where? _______________ _______________________________ What type of food do you eat there? _______________________**

____

2) Home Meals **Do you prepare meals at home? _____ If so, how often? _________________________**
If yes, what type of food do you prepare? ____

____

3) Meal Habits **Do you (circle) a) skip meals often b) have irregular eating times c) Eat past 7 PM d) love to eat junk food or snacks in the evening**

4) MSG **Do you avoid food/drinks that list "natural flavors" on the label? ______________**

5) Water **Do you drink tap water? ______ Bottled water? ______ If yes, what is the brand? _____________ If you have a home water purifier, when was the cartridge last changed? _______________**

Typical Diet

Please fill out typical diet <u>for the last few weeks.</u> Please be as detailed as possible. For example, instead of writing 'chicken', identify how it was made such as baked, fried, etc. Instead of writing 'salad', identify what was in the salad and type of dressing. ***Please be honest.***

BREAKFAST: (Time eaten: _______) ____

____

____

____

LUNCH: (Time eaten: _________) ____

____

____

____

____

DINNER: (Time eaten: ________) ____

____

____

____

____

SNACKS (Time eaten: ________) ____

Patient Agreements

I understand that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that any future insurance problems, situations, etc. that arise with my insurance carrier will have to be addressed by myself.

I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment of all services and products.

I understand that I am responsible for payment of any laboratory services that are prescribed for me by the doctor at the time the kit is received. I further understand that if I return a prepaid laboratory test kit for a refund of moneys, there will be a $50.00 administrative processing fee, and that the return of funds may take up to 30 days from the time of the test kit return. In addition, I understand that there will be no return of funds if I choose to return prepaid laboratory test kits after 90 days.

If I am prescribed nutritional supplementation and elect to purchase these products it is my understanding that I cannot return for refund any refrigerated items at any time or any other product after 90 days. A 15% restocking fee may be charged for returned products.

I hereby authorize the doctor to treat my conditions(s). The doctor will not be held responsible for any pre-existing medically diagnosed condition (by another doctor), or any previous medical diagnosis.

***Attention Blue Cross Blue Shield insurance patients:

The doctors of this clinic are providers with Blue Cross Blue Shield of Minnesota for chiropractic services only. Specialized laboratory test procedures, acupuncture, laser and nutritional consultations are considered a non covered service through this office and I fully understand that I am responsible for the payment of these services in full at the time services are received. I understand completely that these services will not be submitted to Blue Cross Blue Shield or any of their affiliate companies. I understand that there may be treatment and fee schedule limitations that I will have to abide by for chiropractic services.
If I have an insurance deductible with Blue Cross Blue Shield for covered services, I understand and agree to pay in full for all services until I have met the deductible amount.

The applied kinesiology testing procedure portion of the initial chiropractic exam is a non-covered service. I understand and agree to personally pay that portion in full.

The insurance company does not pay for all reexaminations under chiropractic. I will be personally responsible for them.

Nutritional supplements, pillows, orthotics or other miscellaneous supplies are non-covered items.

I have read and fully understand the above information regarding laboratory tests, insurance and payments and I am clear on the policy of this clinic. The above policy applies to all future testing and treatment as well.

X____ ________________________________
Patient/Parents Signature Date

X____
Printed Name

Medical Symptoms Questionnaire

Name ______________________________ **Date** _________________

Rate each of the following symptoms based upon your typical health profile for:
Past 30 days

Point Scale

0 - *Never* or *almost never* have the symptom
1 - *Occasionally* have it, effect is *not severe*
2 - *Ocasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

HEAD

________ Headaches
________ Faintness
________ Dizziness
________ Insomnia

Total ________

EYES

________ Watery or itchy eyes
________ Swollen, reddened or sticky eyelids
________ Bags or dark circles under eyes
________ Blurred or tunnel vision
(does not include near or far-sightedness)

Total ________

EARS

________ Itchy ears
________ Earaches, ear infections
________ Drainage from ear
________ Ringing in ears, hearing loss

Total ________

NOSE

________ Stuffy nose
________ Sinus problems
________ Hay fever
________ Sneezing attacks
________ Excessive mucus formation

Total ________

MOUTH/THROAT

________ Chronic coughing
________ Gagging, frequent need to clear throat
________ Sore throat, hoarseness, loss of voice
________ Swollen or discolored tongue, gums, lips
________ Canker sores

Total ________

SKIN

________ Acne
________ Hives, rashes, dry skin
________ Hair loss
________ Flushing, hot flashes
________ Excessive sweating

Total ________

HEART

________ Irregular or skipped heartbeat
________ Rapid or pounding heartbeat
________ Chest pain

Total ________

LUNGS

________ Chest congestion

	______	Asthma, bronchitis	
	______	Shortness of breath	
	______	Difficulty breathing	Total ______
DIGESTIVE TRACT	______	Nausea, vomiting	
	______	Diarrhea	
	______	Constipation	
	______	Bloated feeling	
	______	Belching, passing gas	
	______	Heartburn	
	______	Intestinal/stomach pain	Total ______
JOINTS/MUSCLE	______	Pain or aches in joints	
	______	Arthritis	
	______	Stiffness or limitation of movement	
	______	Pain or aches in muscles	
	______	Feeling of weakness or tiredness	Total ______
WEIGHT	______	Binge eating/drinking	
	______	Craving certain foods	
	______	Excessive weight	
	______	Compulsive eating	
	______	Water retention	
	______	Underweight	Total ______
ENERGY/ACTIVITY	______	Fatigue, sluggishness	
	______	Apathy, lethargy	
	______	Hyperactivity	
	______	Restlessness	Total ______
MIND	______	Poor memory	
	______	Confusion, poor comprehension	
	______	Poor concentration	
	______	Poor physical coordination	
	______	Difficulty in making decisions	
	______	Stuttering or stammering	
	______	Slurred speech	
	______	Learning disabilities	Total ______
EMOTIONS	______	Mood swings	
	______	Anxiety, fear, nervousness	
	______	Anger, irritability, aggressiveness	
	______	Depression	Total ______
OTHER	______	Frequent illness	
	______	Frequent or urgent urination	
	______	Genital itch or discharge	
			Total ______
GRAND TOTAL			***TOTAL*** ______

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