Thrive! Health & Wellness

NEW PATIENT INFORMATION FORM

Please print clearly.

Name_____ Date_____

Address _____ Apt.# _____

City _____ State_____ ZIP_____

Home Phone (____) ____-_____Cell Phone (____) ____-_____

Carrier (for text alerts)_____e-mail address: _____

REFERRED BY:_____

Occupation _____ Employer_____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Your overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

What are your one or two primary reasons for seeking our services?

Reason 1 (explain): _____ Date symptoms first occurred: _____ Frequency of symptoms:_____ What makes condition improve?_____

What makes conditions worse? _____

Do you think this problem will resolve itself? Yes No

Previous treatments for this complaint _____

_____

Age when symptoms were first observed:_____When did you last feel well (absent of all symptoms)? _____

Did you suffer from any type of physical, chemical or emotional trauma just before your symptoms were first observed? _____ If so, briefly describe:

_____

Have your symptoms ever gone away for any period of time? _____

If yes, when & why? _____

Reason 2 (explain): _____ Date symptoms first occurred: _____ Frequency of symptoms:_____ What makes condition improve?_____

What makes conditions worse? _____

Do you think this problem will resolve itself? Yes No

Previous treatments for this complaint _____

_____

Age when symptoms were first observed:_____When did you last feel well (absent of all symptoms)?

_____

Did you suffer from any type of physical, chemical or emotional trauma just before your symptoms were first observed? _____ If so, briefly describe:

_____

Have your symptoms ever gone away for any period of time? _____

If yes, when & why? _____

Other complaints or problems: (use separate sheet if needed) _____

_____

What will your health be like 5 years from now if you keep doing what you are doing right now? Better, same, worse? _____

Current medications/drugs being taken: _____

_____

Are you currently under the care of a physician or other health care professionals?(If yes, please give name and date of last visit):_____

Nutritional supplements you are taking (with brand): _____

Current dietary preference (circle one): Vegan/Vegetarian/Omnivore

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol_____

How many times a day do you poop ☺? _____ or Don't Poop Daily? _____

Is it always brown? _____ If not what color? _____

Have you been diagnosed with any of the following (in past or current medical condition): ( )Heart Disease ( )Kidney Problems ( )Stroke ( )Seizure Disorder ( )Thyroid Problems ( )Arthritis ( )High Blood Pressure ( )Glaucoma ( )Diabetes ( )Obesity

( )High Cholesterol ( )Ulcers ( )Periodontal Disease ( )Oral Gum/Bone Problem

( )Cancer ( )Whiplash ( )Liver Desease ( )Cataracts ( )Depression ( )Manic-Depressive Disorder

How often do you get a cold?_____

If your family has a history of any of the following, please:

a. Circle the condition and b. write "F" for father, "M" for mother, and "S" for sibling within the parentheses:

( )Acne ( )Anaphilic Reactions ( )Asthma ( )Alcoholism ( )Cancer ( )Diabetes

( )Depression/Moods ( )Eczema ( )Epilepsy ( )Early Senility ( )Herpes ( )Hepatitis

( )Heart Disease ( )High Blood Pressure ( )Hysterectomy ( )Intestinal Disorders

( )Kidney Disorders ( )Manic-depressive Disorder ( )Neurological Disorders ( )Obesity ( )Stroke ( )Schizophrenia ( )SeizureDisorders ( )ThyroidCondition

( )_____ ( )_____ ( )_____ ( )_____

List all known allergies to foods, grasses, trees etc. (including medications):

No Known Allergies (Other possible allergies may include sulfa, latex, aspirin, lidocaine, penicillin, beef products)

_____

_____

Do notice anything about the smell of gasoline?_____

Do you react to strong smells or perfumes or other smells?_____

Do you suffer from headaches? Yes No (If yes) How often per month?_____

Have you ever had a flu shot or any other adult vaccine (please list)?_____

Did you receive all childhood vaccines?_____

List any handicaps or impairments (such as vision or hearing loss): _____

List any foreighn travel for the past two years (destination and date):_____

What are your wellness goals and purpose in pursuing this process today? _____

_____

_____

What is your activity level?

Exercise 1-3x p/week 3-5x p/week 5-7x p/week Light (10-15 min) Moderate (15-30 min) Aggressive (40-80 min)

Aerobics Y/N Light (10-15 min) Moderate (15-30 min) Aggressive (40-80 min)

Weights Y/N Light (10-15 min) Moderate (15-30 min) Aggressive (40-80 min)

What is your exercise weight/goal? _____

Rate your interest in overall wellness: Low Med High Very High

How motivated are you to make the changes necessary to increase your overall wellness?

Low Med High Very High

What should you do that you know you don't when it comes to your health?

_____

What do you have the most trouble changing in your health habits?

_____

List any major or childhood illnesses (with approx. dates; colic, ear aches, mumps, measles, chicken pox, shingles, etc): _____

List any surgery or operations with approx. date:_____

_____

Tonsils_____ Adenoids_____ Appendix _____ Gallbladder _____ Wisdom Teeth _____ C-Sections _____ Hysterectomy _____

Any Complications? _____Antibiotics Use:None Some Moderate Severe

Infections: Chronic Yes No Some Moderate Extreme Explain: _____

_____

Acne: None Some Moderate Severe Treatment: _____

Past Accidents or injuries: _____

_____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ____

Name of Child Age Sex Any physical conditions or concerns?

_____ ____ M/F _____

_____ ____ M/F _____

_____ ____ M/F _____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other

Any household pets or other animals you or family members are in close contact with:

_____

What health goals can we help you acheive? _____

_____

What would you say is your biggest barrier to healing? _____

_____

Would you like something natural to take care of your symptoms or would you like to no longer have to manage the symptoms?

_____

What might you be putting in your mouth that could be contributing to your illness?

_____

What might you be putting on your skin that is contributing to your illness?_____

_____

What type of work have you (or your parents) done that would expose you to chemicals, pesticides, metal products, herbicides, cleaning products, etc? For how long were you exposed to these types of products?_____

_____Where were you born? _____ Where were you raised? _____

Have you ever sourced drinking water from a well for an extended period of time?_____

What is your energy level? Low 1 2 3 4 5 6 7 8 9 10 High

Circle All That Apply:

Dental: Root Canals Y/N Metal Fillings Y/N Abscesses Y/N Implants Y/N Dentures Y/N

Is there a history of: Mono, Coxsackie (Hand, Foot, Mouth), Epstein Barr Virus, Cytomegalovirus, Herpes 1 or 2? Yes/No

(which)_____

Is there a history or possibility of ulcers? Y/N Explain: _____

_____

Do you see a chiropractor? y/n Which areas of the spine are typically an issue?

If you know the specific vertibrea, please note that next to the area.

C1-7 _____ T1-12 _____ L1-5 ____ Sacrum _____ Coccyx ____

Any other areas typically needing adjustment? _____

Where you born through a vaginal birth? Y/N

Where you breastfed? Y/N