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| A screenshot of a cell phone  Description automatically generated  **WellSpring: Integrative Health Care**  3221 S Cherokee Lane Ste 1830  Woodstock, Ga 30188  770.376.0632 |  |

**DEMOGRAPHIC INFORMATION**

Name Today’s Date

Address Employer

City, State, Zip: Type of work

Email If retired, what was your occupation?

Phone (home) (cell) (work)

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Travel time to this office

Gender: □F □M □ Other  □ Enrolled in Medicare? Height: \_\_\_\_\_ ft \_\_\_\_\_ in  Current weight:

Marital Status: □S □M □W □D □Partnered Lowest adult weight \_\_\_\_\_ Highest \_\_\_\_\_ Desired

Name of Spouse/Partner Medical Doctor

Spouse’s Occupation Referred to our office by

Name(s) and Age(s) of Children

Other Household Members (include extended family, non-family and pets)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person responsible for payment of professional services

Practitioners at the center you have previously seen in our office. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT HEALTH REPORT**

Please describe the principal health problems for which you would like to come to this office. Include approximate date of onset.

\* Type: P=Pain; A=Ache; ST=Stiffness; N=Numbness; T=Tingling; S=Soreness; O=Other

\*\* Pain: For each complaint, rate the level of current pain on a scale of 1-10. 1=no pain; 10=severe pain

Principal Health Problems Type \* Pain \*\*

1.

2.

3

What are your long-term goals in coming to this office?

How long has it been since you have felt well?

Are your present complaints due to an injury? □no □yes □auto accident □ other

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your condition getting progressively worse? □ no □ yes  Pain is: □ constant □ comes and goes

Is your condition interfering with your: □ work □ sleep □ daily routine □ other

Have you lost any days of work? □ no □ yes Dates

What activities aggravate your condition?

What makes it feel better?

Have you had this or a similar condition before? □ no □ yes If yes, explain

Has anyone in your family had a similar condition before? □ no □ yes If yes, who?

Past chiropractic treatment □ no □ yes When? \_\_\_\_\_\_\_\_\_\_\_\_ Explain

Have you seen any other physicians for this condition?

Do you wear: □ Glasses/contacts □ Heel lifts □ Orthotics □ Dental night guard

Did/do you wear dental braces? □no □ yes When?

Have you been treated for any other health condition by a physician in the last year? □ no □ yes If yes, explain:

Are you currently taking prescription medication? □ no □ yes If yes, what?

Have you ever been on frequent or prolonged antibiotic therapy (such as erythromycin, penicillin, tetracycline, etc.)?

How many rounds?

Current non-prescription pain relievers (Alleve, Tylenol, Aspirin, Ibuprofen, etc.). How many per day?

Other current non-prescription medications (laxatives, antihistamines, decongestants, stimulants, etc.):

Are you currently taking any vitamins or supplements? □ no □ yes If yes, what?

Allergies or sensitivities to drugs, foods, pollens, chemicals, animals, etc.

**HABITS OF DAILY LIVING**

**Exercise:** □ None □ Moderate □ Heavy  □ <1 per week □ 1-3 times per week □ Daily  Hours/ week

**Work Activity** (check all that apply): □ Sitting □ Standing □ Walking □ Light Labor □ Heavy Labor

**Stress level:** □ High □Moderate □ Low  Do you do any stress reduction or relaxation activities such as meditation, yoga, prayer, etc.?

Are you currently on psychotropic medication or receiving psychological counseling? Please describe:

What are your favoritehobbies or other life interests?

**Sleep habits**: Hours per night \_\_\_\_\_\_\_\_\_\_\_\_ Restless or restful? \_\_\_\_\_\_\_\_\_\_\_\_ Do you dream?

What time do you go to bed? \_\_\_\_\_\_\_\_\_\_\_\_\_ Do you sleep through the night?

**Alcohol consumption**: Drinks per week \_\_\_\_\_\_\_\_\_\_\_\_ Have you ever felt the need to cut down?

**Tobacco consumption:** Do you smoke? \_\_\_\_\_\_\_\_\_ How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long?

Did you ever smoke? \_\_\_\_\_\_\_\_\_\_ How much for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did you stop?

**Non-medical drug use:** Type and frequency

**Chemical exposure:** Do you regularly use:□ Cosmetics □ Perfumes □ Aftershaves □ Scented soaps/products

Do you have amalgam dental fillings? □ yes □ no  Any prolonged exposure to paints or solvents? □ yes □ no

Other known notable chemical exposures:

**Diet:** Do you eat regular meals? □ yes □ no  Do you sit down for meals? □ yes □ no  Do you normally eat or drink between meals? □ yes □ no What?

How often does your diet consist mainly of some or all of the following: salads, whole grains, eggs, fresh fruits and vegetables, lean meats, beans or legumes? □ rarely □ sometimes □ often □ almost always

Are you a vegetarian? □ yes □ no  Do you eat processed foods with artificial colorings, flavorings or preservatives (e.g. bologna, sausage, cheese spreads, baked goods)? □ rarely □ sometimes □ often

Do you eat “fast food”? □ rarely □ sometimes □ often What and how often?

Do you add sugar to coffee, tea, cereals, other foods? □ yes □ no  Do you use artificial sweeteners? □ yes □ no

How many servings of:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_ Fruit/day | \_\_\_\_ Fish/week | \_\_\_\_ Water/day | \_\_\_\_ Tea/day |
| \_\_\_\_ Vegetables/day | \_\_\_\_ Fowl/week | \_\_\_\_ Soft Drinks/day | \_\_\_\_ Chocolate/Cocoa/day |
| \_\_\_\_ Sweets/day | \_\_\_\_ Red meat/week | \_\_\_\_ Coffee/day | \_\_\_\_ Cow dairy/day |
| \_\_\_\_ Wheat (bread etc.)/day |  |  | (cheese, milk, yogurt) |

**GENERAL HEALTH HISTORY**

List any major accidents, serious falls or injuries (with dates)

Broken bones and cranial injuries

List surgeries and dates

List X-rays or special imaging taken in the last 10 years and their dates

Please check all that you have or have had:

|  |  |  |  |
| --- | --- | --- | --- |
| □ Alcoholism | □ Diabetes | □ Learning Disability | □ Polio |
| □ Anemia | □ Dyslexia | □ Lupus | □ Rheumatism |
| □ Appendicitis | □ Diverticulitis | □ Migraine Headaches | □ Rheumatoid Arthritis |
| □ ADD/ADHD | □ Epilepsy | □ Malaria | □ Scoliosis |
| □ Osteoarthritis | □ Goiter | □ Mental Illness | □ Stroke |
| □ Cancer | □ Grave’s Disease | □ Multiple Sclerosis | □ Tuberculosis |
| □ Cerebral Palsy | □ Hashimoto’s Disease | □ Muscular Dystrophy | □ Typhoid Fever |
| □ Chronic Fatigue | □ Heart Disease | □ Osteopenia | □ Ulcers |
| □ Cold Sores/Fever Blisters | □ Hepatitis | □ Osteoporosis | □ Venereal Disease |
| □ Colitis/Bowel Disease | □ HIV Positive | □ Pleurisy | □ Whooping Cough |
| □ Crohn’s Disease | □ Influenza | □ Pneumonia | □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Depression | □ Autism |  |  |
|  |  |  |  |

Have you ever lived or traveled outside of the United States? □ yes □ no  Had travelers diarrhea? □ yes □ no

Have you ever been tested for intestinal parasites? □ yes □ no  Been treated for intestinal parasites? □ yes □ no

If yes, please describe when, and what parasite(s)

**CHILDHOOD HISTORY**

Were you adopted? \_\_\_\_\_\_\_\_\_\_ If so, at what age? \_\_\_\_\_\_\_\_\_\_Were you breast or bottle fed? \_\_\_\_\_\_\_\_\_\_

Vaginal birth or C-section? \_\_\_\_\_\_\_\_\_\_ Complications?

Childhood illnesses:

|  |  |  |  |
| --- | --- | --- | --- |
| □ Bronchitis | □ Allergies | □ Measles | □ Rheumatic Fever |
| □ Recurrent Colds | □ Colic | □ Mumps | □ Frequent Antibiotics |
| □ Ear Infections | □ Persistent Diaper Rashes | □ Rubella | number of times \_\_\_\_ |
| □ Tonsilitis | □ Bedwetting | □ Chicken Pox | □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Was your home life (check all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
| □ Loving | □ Fun | □ Loud | □ Alcoholic |
| □ Supportive | □ Educational | □ Argumentative | □ Physically Abusive |
| □ Peaceful | □ Stressful | □ Single Parent | □ Verbally Abusive |
| □ Filled with positive  extended family | □ Financially Stressed | □ Lonely or Neglectful | □ Sexually Abusive |

Comments:

**FAMILY HISTORY**

Diabetes Heart Disease/High Cancer Musculoskeletal Other

Blood Pressure Problems

Grandparent(s) □. □. □. □. □.

Mother □. □. □. □. □.

Father □. □. □. □. □.

Sibling(s) □. □. □. □. □.

Number of siblings \_\_\_\_\_\_\_ Sibling age(s) and health status

Age of biological parents \_\_\_\_\_\_\_\_\_\_ If deceased, age and cause:

**SYSTEMS REVIEW**

Please write: C = Constantly in the present O = Occasionally in the present P = In the past

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **GENERAL** | |  | **MUSCLES & JOINTS** |  | **CARDIOVASCULAR** | |  | **RESPIRATORY** | |  | |
| \_\_\_\_\_ | Allergies | | \_\_\_\_\_ | Arthritis | \_\_\_\_\_ | Easy Bruising | | \_\_\_\_\_ | Asthma | |  | |
| \_\_\_\_\_ | Chills | | \_\_\_\_\_ | Bursitis | \_\_\_\_\_ | Hardening of arteries | | \_\_\_\_\_ | Chest pain | |  | |
| \_\_\_\_\_ | Convulsions | | \_\_\_\_\_ | Hernia | \_\_\_\_\_ | High blood pressure | | \_\_\_\_\_ | Chronic cough | |  | |
| \_\_\_\_\_ | Dizziness | | \_\_\_\_\_ | Leg cramps when | \_\_\_\_\_ | Low blood pressure | | \_\_\_\_\_ | Difficulty breathing | |  | |
| \_\_\_\_\_ | Fainting | |  | walking | \_\_\_\_\_ | Pain over heart | | \_\_\_\_\_ | Spitting blood | |  | |
| \_\_\_\_\_ | Fatigue | | \_\_\_\_\_ | Low back pain | \_\_\_\_\_ | Poor circulation | | \_\_\_\_\_ | Spitting phlegm | |  | |
| \_\_\_\_\_ | Fever | | \_\_\_\_\_ | Musculoskeletal birth | \_\_\_\_\_ | Rapid heart | | \_\_\_\_\_ | Wheezing | |  | |
| \_\_\_\_\_ | Headache | |  | defects | \_\_\_\_\_ | Slow heart | |  |  | |  | |
| \_\_\_\_\_ | Loss of Sleep | | \_\_\_\_\_ | Neck pain or stiffness | \_\_\_\_\_ | Swelling ankles | |  | **GENITO-URINARY** | |  | |
| \_\_\_\_\_ | Nervousness | | Pain, numbness or tingling in: | | \_\_\_\_\_ | Varicose veins | | \_\_\_\_\_ | Bed wetting | |  | |
| \_\_\_\_\_ | Night Sweats | | \_\_\_\_\_ | Shoulders |  |  | . | \_\_\_\_\_ | Blood in urine | |  | |
| \_\_\_\_\_ | Thirst Abnormal | | \_\_\_\_\_ | Arms | **EYE/EAR/NOSE/THROAT** | | | \_\_\_\_\_ | Frequent urination | |  | |
| \_\_\_\_\_ | Weight Loss | | \_\_\_\_\_ | Elbows | \_\_\_\_\_ | Crossed eyes | | \_\_\_\_\_ | Incontinence | |  | |
| \_\_\_\_\_ | Weight Gain | | \_\_\_\_\_ | Hands | \_\_\_\_\_ | Dry eyes | | \_\_\_\_\_ | Kidney infection | |  | |
|  |  | | \_\_\_\_\_ | Hips | \_\_\_\_\_ | Eye pain | | \_\_\_\_\_ | Kidney stones | |  | |
| **GASTRO-INTESTINAL** | |  | \_\_\_\_\_ | Legs | \_\_\_\_\_ | Farsightedness | | \_\_\_\_\_ | Night urination | |  | |
| \_\_\_\_\_ | Belching or gas | | \_\_\_\_\_ | Knees | \_\_\_\_\_ | Nearsightedness | | \_\_\_\_\_ | Painful urination | |  | |
| \_\_\_\_\_ | Colon trouble | | \_\_\_\_\_ | Feet | \_\_\_\_\_ | Light sensitivity | | \_\_\_\_\_ | Prostate trouble | |  | |
| \_\_\_\_\_ | Constipation | | \_\_\_\_\_ | Painful tailbone | \_\_\_\_\_ | Earache | |  |  | |  | |
| \_\_\_\_\_ | Diarrhea | | \_\_\_\_\_ | Paralysis | \_\_\_\_\_ | Ear discharge | |  | **FOR WOMEN ONLY** | |  | |
| \_\_\_\_\_ | Excessive hunger | | \_\_\_\_\_ | Poor posture | \_\_\_\_\_ | Ear noises | | \_\_\_\_\_ | Cramps or backache | |  | |
| \_\_\_\_\_ | Gall bladder trouble | | \_\_\_\_\_ | Sciatica | \_\_\_\_\_ | Hearing difficulty | | \_\_\_\_\_ | Excessive flow | |  | |
| \_\_\_\_\_ | Hemorrhoids (piles) | | \_\_\_\_\_ | Stiff neck | \_\_\_\_\_ | Hearing sensitivity | | \_\_\_\_\_ | Hot flashes | |  | |
| \_\_\_\_\_ | Intestinal parasites | | \_\_\_\_\_ | Spinal curvature | \_\_\_\_\_ | Nasal obstruction | | \_\_\_\_\_ | Irregular cycle | |  | |
| \_\_\_\_\_ | Jaundice | | \_\_\_\_\_ | Swollen joints | \_\_\_\_\_ | Nose bleeds | | \_\_\_\_\_ | Lumps in breast | |  | |
| \_\_\_\_\_ | Liver trouble | |  |  | \_\_\_\_\_ | Sinusitis | | \_\_\_\_\_ | Miscarriage | |  | |
| \_\_\_\_\_ | Nausea | |  | **SKIN** | \_\_\_\_\_ | Stuffy nose | | \_\_\_\_\_ | Painful periods | |  | |
| \_\_\_\_\_ | Pain over stomach | | \_\_\_\_\_ | Boils | \_\_\_\_\_ | Hay fever | | \_\_\_\_\_ | PMS | |  | |
| \_\_\_\_\_ | Poor appetite | | \_\_\_\_\_ | Bruising easily | \_\_\_\_\_ | Frequent colds | | \_\_\_\_\_ | Vaginal discharge | |  | |
| \_\_\_\_\_ | Poor digestion | | \_\_\_\_\_ | Dryness | \_\_\_\_\_ | Hoarseness | | **□**Y **□**N | | Pregnant at this time? | | |
| \_\_\_\_\_ | Vomiting | | \_\_\_\_\_ | Eczema | \_\_\_\_\_ | Sore throats | | Last Pap | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  |  | | \_\_\_\_\_ | Psoriasis | \_\_\_\_\_ | Enlarged glands | | Menstrual cycle: \_\_\_\_\_\_ days | | |  |  |
|  | **THYROID** | | \_\_\_\_\_ | Hives or allergies | \_\_\_\_\_ | Enlarged thyroid | | Date of last period: \_\_\_\_\_\_\_\_\_ | | |  |  |
| \_\_\_\_\_ | Overactive | | \_\_\_\_\_ | Itching | \_\_\_\_\_ | Dental decay | |  | | |  |  |
| \_\_\_\_\_ | Underactive | | \_\_\_\_\_ | Sensitive skin | \_\_\_\_\_ | Grinding teeth | |  |  | |  | |
| \_\_\_\_\_ | Enlarged | | \_\_\_\_\_ | Skin eruptions |  |  | |  |  | |  | |

Your completion of this Intake Form will help us determine whether our services might meet your needs. Upon our review of this Form, we will contact you to set up an initial appointment as a new patient, or, if we believe that the Practice’s services may not meet your needs, we may offer to discuss possible alternative practitioners in our facility. In both cases, we will maintain the information you have provided in this Intake Form in a confidential manner in accordance with our privacy practices, regardless of whether you become a patient of the Practice.

Please note that each practitioner practicing in our facility owns and operates his/her own clinical practice and is not affiliated with WellSpring:IHC. While we may work closely with the practitioner(s) we discuss with you, we are not liable for any care or treatment provided by him/her. In addition, we would like to remind you that you have the right to seek your treatment and care from any practitioner at any facility you choose.

**Because some of our patients have allergies, we ask you not to wear scented products (e.g., perfumes, hair products, aftershaves, clothing dried with Bounce® dryer sheets) to this office. Please check here to acknowledge this request: □**