Whole Health Associates

(New Patient Application)

Personal Information Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Spouse or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street, City, State, Zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status M S W D Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No. of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to send health information Y/N

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (Name and Phone): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Health Information

Check the following conditions you may have had or have now:

Allergy Diarrhea Measles Rheumatic Fever

Alcoholism Eczema Miscarriage Stroke

Anemia Emphysema Multiple Sclerosis Heart Attack

Arteriosclerosis Gall Bladder Mumps Tuberculosis

Arthritis Gout Neuritis Thyroid Problems

Backaches High Blood Pressure Nervousness Ulcers

Cancer Heart Disease Depression Venereal Disease

Convulsions Malaria Pleurisy Whooping Cough

Constipation Menstrual Cramps Pneumonia Low Blood Sugar

Cold Sores Irregular Periods Polio Neck Pain

Diabetes Migraine Headaches  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sinus Epilepsy Ringing in Ears  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any of the conditions below that have affected anyone in your family (parents, grandparents, siblings, children, grandchildren):

Cancer High Blood Pressure Heart Attack Stroke Heart Disease

Asthma Allergies Mental Illness Tuberculosis Autoimmune Disease

Diabetes Osteoporosis Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all surgeries and hospitalizations:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List below your five greatest health concerns in order of significance to you:

1.

2.

3.

4.

5.

On a scale of 1-10 how strong is your resolve to do what it takes to correct these health problems? \_\_\_\_\_\_\_\_

There are three major components to great health. These three areas need ongoing attention. They are your structure (musculoskeletal system), chemical (your internal body chemistry) and your mental/emotional state (stress, emotions, and mental outlook). Please provide us information about these areas.

STRUCTURAL

Rate Your Posture: Poor 12345678910 Excellent

What physical traumas have you had? Birth Injury Broken Bones Concussion Sports Injury

Auto Accident Falls Other

Aches and Pains? Head Neck Shoulder Elbow Wrist/Hand Mid Back Lower Back

Hip Knee Ankle/Foot

What do you do to care for and maintain good structural health? Chiropractic Physical Therapy

Massage Exercise Stretching Weight/Resistance Training Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHEMICAL

What prescription and nonprescription drugs are you taking?

How would you rate your diet? Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Have you had any abnormal lab findings? Yes No If Yes, describe:

Are you aware of any hormonal or endocrine problems? Yes No If Yes, describe:

What are you doing to balance your body chemistry? Vitamins Minerals 1 or more Fresh Fruit/Day

1 or more Fresh Vegetables/Day Half your body weight in ounces of water/day

Avoid Certain Foods, if so please list:

MENTAL/EMOTIONAL

Rate Your Stress Level: None 1 2 3 4 5 6 7 8 9 10 Extremely High

If it is high, what do you feel is the greatest source of your stress?

How many hours of sleep do you get?

Do you work long hours? Yes No If yes how many hours do you average per day?

Are you able to relax and unwind? Yes No

Do you feel that your relationships are unhealthy? Yes No If yes, explain:

What specific things are you doing to support your mental/emotional health? Yoga R&R Breathing Exercises Meditation Spiritual Practice Support Group Counseling Vacation  Other: