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 [ ] 1[ ] 2[ ] 3[ ] 4[ ] 5[ ] 6[ ] 7[ ] 8[ ] 9[ ] 10 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: