Aloha Wellness - Chiropractic

Patient Data

First Name __________________ Last Name _____________________ Soc Sec # ____-___-___
Street Address ____
City ___________________ State _____ Zip ________ Age _____ Birth Date _______________
Telephone (Cell) _______________ (Work) __________________ (Home) __________________
Marital Status: Single Married Divorced Widowed
Email* ____
* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Health History

Reason for seeking chiropractic care ____
____
Describe any health problems, including how long you've had them _______________________
____
____
Are you under the care of any other doctor? _______ If yes, the conditions being treated?
____
List any current medications: ____
List any x-rays you've had in the past 2 years ____
Chiropractic History:
Have you ever been to a chiropractor before? _____ If yes, Doctor's Name:_________________
Date of last chiropractic visit:_______ Reason for care ___________________________________
Date of last chiropractic X-rays:________ How long were you under care? __________________
Are other family members under chiropractic care? _____ Who?___________________________

Personal and Family

Occupation ___________________________ Work duties _______________________________
Employer/Address ____
Spouse's Name ________________________ Spouse's Health Status ______________________
Spouse's Occupation ____________________ Spouse's Employer __________________________
Number of Children ____ Children's Age and Health Status ______________________________

Wellness Commitment

At Aloha Wellness, we are dedicated towards our members achieving the goal of Whole Body Vitality. To better help you achieve this, we need to understand your commitment towards being well. Based on a scale of 10 to 100%, please circle your personal level of commitment toward obtaining and maintaining your Whole Body Vitality.

10% --- 20% --- 30% --- 40% --- 50% --- 60% --- 70% --- 80% --- 90% --- 100%

How did you hear about our clinic, or who referred you? ______________________________

Aloha Wellness

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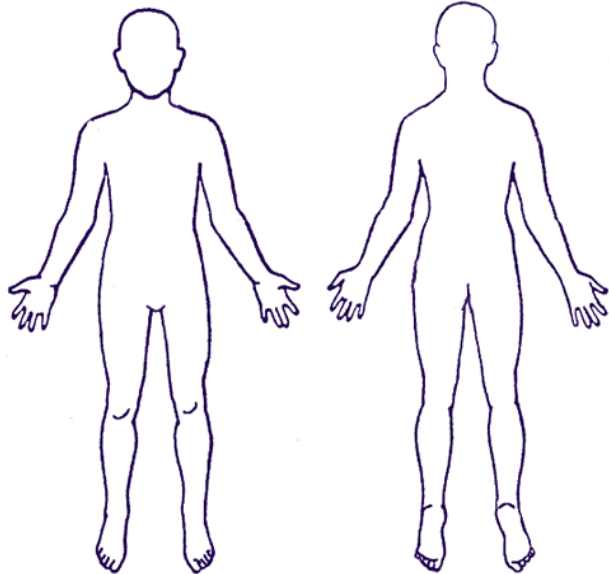
If you have had the following, or if you suffer from the following, *Please Check*		
Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	☐	☐
Migraines	☐	☐
Neck Pain	☐	☐
Shoulder Pain	☐	☐
Arm/hand Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Hip Pain	☐	☐
Leg/foot Pain	☐	☐
Disc Problems	☐	☐
Arthritis	☐	☐
Other Joint Pain	☐	☐
Numbness	☐	☐
Joint Swelling	☐	☐
Dizziness	☐	☐
Nausea	☐	☐
Weakness	☐	☐
Fatigue	☐	☐
Nervousness	☐	☐
Insomnia	☐	☐
Heart Problems	☐	☐
Vision Changes	☐	☐
Nose Bleeds	☐	☐
Ringing in Ears	☐	☐
Earaches	☐	☐
Hearing Loss	☐	☐
Cough	☐	☐
Chest Pain	☐	☐
Female Problems	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Diabetes	☐	☐
Hypoglycemia	☐	☐
Digestive problem	☐	☐
Urinary problem	☐	☐
Frequent colds	☐	☐
Skin conditions	☐	☐
Other _______	☐	☐

Circle the areas where you have any problems. Please describe these problems.

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.



A=Ache

B=Burning

N=Numbness

O=Other

P=Pins & Needles

S=Stabbing

Below, please fill in any other health information you feel we might need for your care.

____

Signatures

Emergency Contact ___________________________________ Phone _________________

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The Doctor will not be held responsible for any pre-existing diagnosed conditions nor for any medical diagnosis. Further, the patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's signature ______________________________________ Date ________________

Spouse's or guardian's signature ___________________________ Date ________________