WELLNESS
PITTSBURGH
chiropractic · massage · nutrition

PERSONAL CONTACT INFORMATION

Today's Date:_____ Date of Birth:_____

Last Name:_____ First:_____ Middle Initial: _____ Nickname?_____

Address: _____

City: _____ State:_____ Zip: _____

Home Phone: _____ Preferred daytime number to reach you? H / C / W

Cell Phone: _____Work Phone: _____

Email Address: _____

Occupation:_____Employer:_____

Whom may we thank for referring you to our office? _____

Emergency Contact: _____ Relationship: _____

Phone numbers: _____

REASON FOR VISIT

Are you seeking wellness care? Y / N

Do you have a chief complaint? Y / N (if not, skip to Wellness Questionnaire)

If so, please list, then answer the following: _____

When did you first notice your symptom/s (date)? _____

What were you doing when the symptom/s first appeared? _____

Is the condition getting progressively worse? Y / N / not sure

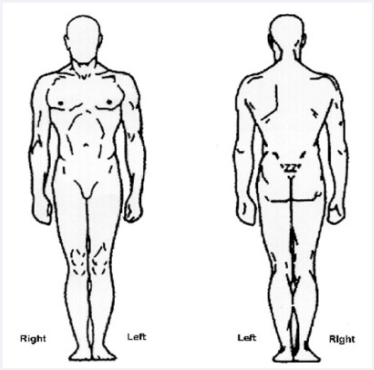
Is it related to an injury? Y / N please list: _____

Have you had this or similar conditions in the past? Y / N

Does it interfere with your Work / Sleep / Daily Routine / Enjoyment of Life / Recreation

How does this make you feel (angry, complacent, sad, etc.)?_____

Mark an X on the specific pain location:



Activities or movements that are painful to perform: Sitting / Standing / Walking / Bending / Lying Down

Rate the severity of your pain:

0 1 2 3 4 5 6 7 8 9 10

No pain **Intolerable pain**

Type of pain: Sharp / Dull / Throbbing / Numb / Aching / Shooting / Burning / Tingling / Cramps / Stiffness / Swelling / Other _____

Would you say the pain is:

____ Minimal (annoyance)
____ Slight (tolerable)
____ Moderate (prevents some activity)
____ Marked (precludes any activity)

Pain interval spacing or frequency:

____ Intermittent (0 – 25% of the time)
____ Occasional (25 – 50% of the time)
____ Frequent (50 – 75% of the time)
____ Constant (75 – 100% of the time)

How often do you have this pain? _____

How long does the pain usually last?_____

Does the pain intensity change? Y / N

Did you have this condition prior to a trauma or accident? Y / N

To your awareness, is the pain related to other conditions or illness? Y / N

If yes, please explain: _____

Why do you think you haven't been able to adapt to this problem? _____

Are you aware your body is self healing and self regulating? _____

Are you aware of the system of the body that controls this regulation? _____

If there is interference to the nervous system, can you ever be 100% healthy? _____

WELLNESS QUESTIONNAIRE

Your care here at Wellness Pittsburgh is ultimately about being as healthy and happy as possible. We will address any immediate needs you have, but our goal is about the big picture. We are here to discover your goals and priorities and to assist you in achieving them! Please help us define what that would like for you.

On a scale of 1 – 10, rate the importance for you to achieve the following:
1 = not important 10 = necessary

Get fit	1	2	3	4	5	6	7	8	9	10
Eat better	1	2	3	4	5	6	7	8	9	10
Reduce stress	1	2	3	4	5	6	7	8	9	10
Stop smoking	1	2	3	4	5	6	7	8	9	10
Reduce pain	1	2	3	4	5	6	7	8	9	10
Increase my mobility	1	2	3	4	5	6	7	8	9	10
Improve my posture	1	2	3	4	5	6	7	8	9	10
Improve my sleep	1	2	3	4	5	6	7	8	9	10
Learn about wellness	1	2	3	4	5	6	7	8	9	10
Learn about wellness products that are right for me	1	2	3	4	5	6	7	8	9	10
Other _____	1	2	3	4	5	6	7	8	9	10

List 3 goals you would love to achieve regarding your perfect health and your ideal life. Use your imagination and assume that anything would be possible for you:

1. _____
2. _____
3. _____

On this scale of 1 – 10 demonstrate what you would be willing to change, let go of, shift, start, or stop in order to accomplish these goals.

1 2 3 4 5 6 7 8 9 10

Not much **Almost anything**

Does it feel possible to you that these goals are achievable for you personally? Y / N

Have you ever attempted to accomplish these goals in the past? Y / N

If yes, what happened and what prevented you from maintaining your

results?_____

Would you be willing to take nutritional supplements to get what's missing from your diet? Y / N

With your commitment and our expertise we can get you as close to your goals as possible!

HEALTH HISTORY

Please circle to indicate if you have had any of the following:

AIDS/HIV	Diabetes	Measles	Rheumatic Fever
Alcoholism	Emphysema	Migraines	Scarlet Fever
Allergy Shots	Epilepsy	Miscarriage	Sexually
Anemia	Fractures	Mononucleosis	Transmitted Disease
Anorexia	Glaucoma	Multiple Sclerosis	Stroke
Appendicitis	Goiter	Mumps	Suicide Attempt
Arthritis	Gonorrhea	Osteoporosis	Thyroid Problems
Asthma	Gout	Pacemaker	Tonsillitis
Bleeding Disorders	Heart Disease	Parkinson's Disease	Tuberculosis
Breast Lump	Hepatitis	Pinched Nerve	Tumors, Growths
Bronchitis	Hernia	Pneumonia	Typhoid Fever
Bulimia	Herniated Disk	Polio	Ulcers
Cancer	Herpes	Prostate Problem	Vaginal Infections
Cataracts	High Blood Pressure	Prosthesis	Whooping Cough
Chemical Dependency	High Cholesterol	Psychiatric Care	Other_____
Chicken Pox	Kidney Disease	Rheumatoid Arthritis	_____
	Liver Disease		_____
			_____

Exercise: None / Moderate / Daily / Heavy

Work Activity:

___Sitting

___Standing

___Light Labor

___Heavy Labor

Are you pregnant? Y / N EDD:_____

Allergies:_____

Medications:_____

_____

Supplements (vitamins, herbs, etc)_____

_____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Broken Bones	_____	_____
Head Injuries	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Name and address of other doctor(s) who have treated you: _____

Do you have any concerns you would like to share that haven't been covered?_____

SIGNATURE ON FILE: I certify that all of the above information is correct to the best of my knowledge. I am hereby authorizing Wellness Pittsburgh, PC, to disclose all pertinent health information to the appropriate parties, always in appliance with HIPAA laws and regulations. I am hereby giving my consent to electronically charge or debit certain accounts for payment for services rendered.

Signature:_____ Date:_____