Wellness 1st Integrative Medical Center, LLC

Please fill out the application ENTIRELY and LEGIBLY. All this information is needed.

Name _____ Nickname_____

Address _____

Phone (Cell)_____ Email _____both are needed for communication

Date of Birth _____ Age _____ On a scale of 1-10, how badly you want to get rid of your problem/s_____

Spouse's Name _____ Phone _____ Occupation _____

Your Prior Occupation _____ Present Occupation _____ Retired? __ Yes __ No

Review of Symptoms

Please check all that apply

___ Foot Pain	___ Diabetes	___Spinal Stenosis	___Cancer	___Pinched Nerve
___ Hand Pain	___ High Cholesterol	___ Degenerative Disc	___ Chemotherapy	___ Poor Circulation
___ Low Back Pain	___ High Blood Pressure	___ Vascular Problems	___ Arthritis in Hands	___Joint Replacement
___ Neck Pain	___ Pacemaker/Defibrillator	___ Leg Pain	___ Arthritis in Feet	___ Foot Surgery
___ Foot Numbness	___ Herniated/Bulging Disc	___ Plantar Fascitis	___ Implanted Cord	___ Bladder Stimulator
___ Poor Wound Healing	___ Hand Numbness	___ Morton's Neuroma	___ Excessive Thirst/Urination	___ Sciatica

Present Health Condition

In order of importance, list the health problems you are most interested in getting corrected:

1. _____
2. _____
3. _____
4. _____

List approximately how long you have noticed these problems:

1. _____
2. _____
3. _____
4. _____

Is there a certain time of day any of these problems are better/worse?

_____

_____

_____

_____

List the things you have used for these problems:

Gabapentin	Neurontin	Lyrica	Cymbalta
Physical Therapy	Pain Medications	Aleve	Tylenol
Ibuprofen	Motrin	Chiropractic	Massage
Injection	Creams	_____	_____

Is your balance/ walking ability affected? If yes, describe:

_____

_____

What do you think is causing your problem?

_____

_____

Name all of doctors you have seen for these problems and treatments you received:

_____

_____

Have your symptoms: _____ Improved _____ Worsened _____ Stayed the same _____ Temporary Relief Only

List anything that makes your condition worse: _____

_____

List anything that makes your condition better: _____

_____

How would you describe the symptoms? Please check ALL that apply

____ Aching Pain	____ Numbness	____ Hot Sensation	____ Cramping	____ Stabbing/Electric Shock
____ Tingling	____ Throbbing Pain	____ Swelling	____ Sharp Pain	____ Pins & Needles Pain
____ Dead Feeling	____ Burning	____ Tiredness	____ Heavy Feeling	____ Cold Sensation

Is this condition interfering with any of the following?

____ Sleep ____ Work ____ Daily Activities ____Recreational Activities ____ Walking ____ Standing _____

Social History & Current Pain Levels

Do you smoke? _____ Yes _____ No **How many daily?** _____ **Do you drink?** _____ Yes _____ No **How many weekly** _____

Do you exercise regularly? _____ Yes _____ No **Describe how often and what type:** _____

How would you rate your pain in the last week?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Previous Health History

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name _____ **Signature** _____ **Date** _____

Please give name, address and office number of your primary care physician.

Name _____ **Phone** _____ **Fax** _____

When were you last seen there? _____

May we send them updates on your treatment/condition? _____ Yes _____ No

List ALL allergies/ sensitivities to medications, foods, and other items here:

Items you react to:	**Reactions:**
_____	_____
_____	_____

List the prescription drugs you are currently taking (or you may attach a list):

Name	**What do you take it for**	**Dose**	**Times Daily**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all nutritional supplements (vitamins, herbs, homeopathic remedies, etc.) as above:

_____	_____	_____	_____
_____	_____	_____	_____