Worthington Wellness Center, P.A.

Identification Information

First Name: ____________________ Last Name: ________________________ Initial ______
Home Address: ______________________________________City__________Zip_________
Home Phone: ( ) ___________________________ Work Phone: ( ) ________________
Mobile Phone: ( ) __________________________ Email: ___________________________
Social Security #: _____________________________ Birth Date: _______________________
Age: ___________ Sex: M F Date: _______________________
Occupation: ______________________________ Employer's Name: _____________________
Work Address: ____
Marital Status: Single Married Divorced Widowed
How were you referred to Worthington Wellness? ____________________________________
____

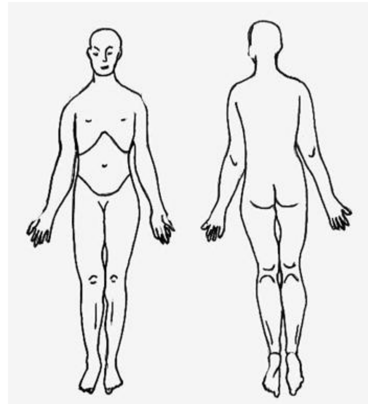
Current Health Complaint

1. What is your major complaint(s)?
____
____

2. When did this symptom(s) begin?
____

Please mark the letter describing your pain on the corresponding area of the diagram to the right.

D Dull Nagging Ache
B Burning
S Sharp / Stabbing
N Numbness / Tingling



General Health Information

1. List all medications you are taking now, including over the counter medication
____
____
____

2. Are you allergic to any medications: Yes, No Please list:
____
____

3. Have you ever had any surgeries or hospitalizations? Yes, No Please list:
____
____
____

4. Have you been x-rayed in the last 12 months? Yes No, When? _________________________
____

5. Have you ever been seen by a chiropractor before: Yes, No Please list:
____

6. Do you have a family physician? Yes, No; Name of physician: _________________________
Clinic Name: _____________________________________Phone: (   )____________________
Address: ____

7. When was your last eye exam? Results?____

8. When was your last dental exam? Results? ____

9. Please place an **N** by any condition you have now, and a **P** next to those you have had in the past.

____Loss of Concentration	____Chest Pain	____Headaches
____Weight gain/loss	____Shortness of Breath	____Gout
____Memory Loss	____Irritable	____Jaw pain
____Dizziness	____Anxiety	____High blood pressure
____Ringing in Ears	____Depression	____Diabetes
____Loss of Balance	____Insomnia	____Convulsions
____Loss of Smell	____Fatigue	____Allergies
____Loss of Taste	____Excess Perspiration	____Anemia
____Pain behind Eyes	____Digestive Trouble	____Heart Disease
____Fainting	____Nausea	____Arthritis
____Palpitation	____Vomiting	____HIV (Aids)
____Vision Problems	____Diarrhea	____High Cholesterol
____Sinus Trouble	____Constipation	____Other (Please List)
____Nervousness	____Cold Hands/feet	________________________
____Cancer	____Gynecological problems	________________________
____Stroke	____Thyroid problems	
____Asthma	____Heart Disease	

10. Do you have, or have you ever had, any diseases or medical problems not listed? Yes, No, if so, please list:
____
____

11. Have you ever had? Motor Vehicle Injury, Sports Injury, Work Injury, Slip and Fall Injury
If yes, please explain: ____
____

12. Any additional information you would like the doctor to know about before beginning care at Worthington Wellness Center: ____
____

Health Habits

Alcohol ___________/wk	Tobacco __________/day	Exercise___________/wk
Caffeine __________/day	Work _____________/wk	Sleep ____________/night
Drugs ________________	Vitamins _____________	

Signature: ____ Date: ____________________