Name				Social Security#	Date
Birth Date	Age	Sex M F		Marital Status M S D W P	# of children
Address					
City		State		ZIP	
Cell Phone					
E-Mail Address				Height Weight	
Company Name				Occupation	
Work Type	Office/Clerical	Light Labor		Moderate Labor	Heavy Labor
Spouses Name				Emergency Contact	

Westside Wellness Center has been offering alternative healthcare for 35 years. Health is a combination of many good habits and minimizing bad habits. Please take a moment and let us know how we can better help you.

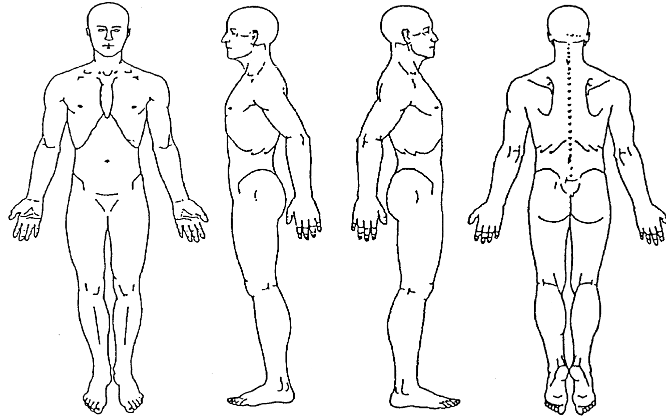
Y	N	Neck Pain	Y	N	Muscle Cramps	Y	N	Shoulder or Arm Pain
Y	N	Back Pain	Y	N	Hepatitis	Y	N	Hip, Leg, Knee or ankle pain
Y	N	Headaches	Y	N	Heart Surgery /Pacemaker	Y	N	Balance problems
Y	N	Foot Pain	Y	N	Stroke	Y	N	Rheumatic Fever
Y	N	Numbness Tingling	Y	N	Shingles	Y	N	Cancer
Y	N	High Cholesterol	Y	N	Anemia	Y	N	Fainting or Seizures
Y	N	Diabetes Type I / II	Y	N	Difficulty Urinating	Y	N	Alcohol / Drug Abuse
Y	N	Sleep Disturbance	Y	N	Asthma / Tuberculosis	Y	N	Osteoporosis
Y	N	High Blood Pressure	Y	N	Chronic Cough	Y	N	Chronic Fatigue
Y	N	Kidney Problems	Y	N	Smoking	Y	N	Constipation / Diarrhea
Y	N	Acid Reflux / Ulcers	Y	N	Chemotherapy	Y	N	Irritable Bowel

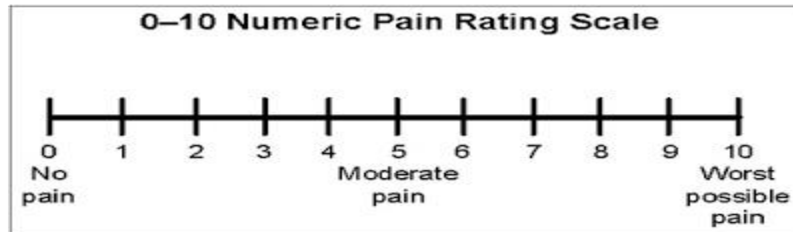
PLEASE LIST ALL INJURIES / TRAUMAS YOU CAN REMEMBER.

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Use the picture below to illustrate your areas of pain, spasm, tingling, or concern.

Make an **X** where you have pain, **N** where there is numbness or tingling





Please list your complaints using the numeric pain scale above.

____

____

FOR WOMEN ONLY :

Tender breasts Mood Swings Insomnia Hysterectomy Hot flashes
Missed periods Weight Gain Fibroids Painful Intercourse Difficult / painful urination
Night Sweats Cysts Number of children?______ Type of delivery_____________
Fatigue Dry skin Cold hands and feet Depression
Cry easily Hair Loss Heavy bleeding during menses Abortion

FOR MEN ONLY:

Weight Gain Difficult/painful urination Painful Intercourse Decreased Libido
Memory Loss Erectile Dysfunction Joint Pains

I understand that all examinations, treatments, supplies and lab work are to be paid for as they are rendered or specific financial arrangements made in advance. There is a charge for missed appointments without a 24 hour notification.

HIPAA ACKNOWLEDGEMENT OF RECEIPT

No information regarding our patients is shared or distributed with any other person or organization without the patient's signed authorization. Your signature below acknowledges receipt of our privacy policy information statement.

____________________________________ ________________________
Signature Date