SOUND BODY
Health & Chiropractic

NEW PATIENT APPLICATION

Patient Name: _____DOB:_____ Age today:____ Today's Date:_____

Address: _____ City: _____ State:_____ Zip: _____

Email: _____ Marital Status: M D W S

Best phone number: _____ Cell ☐ or Landline ☐ Work # _____

Occupation: _____Employer: _____ Night worker? Y / N

In case of an emergency, please contact: _____ Phone:_____

Relationship of emergency contact person to patient: _____

Were you referred by someone? _____

Internet search used? Insurance directory ☐, Google ☐, Yelp ☐, Facebook ☐, Other ☐ _____

Your Primary Physician or other practitioners that you see: _____

Purpose of this appointment: Pain Management/Injury ☐, Nutritional Consult ☐, Function Medicine ☐, Free Consultation ☐, Endo-Nasal Work ☐, CranialSacral Work ☐, CranialSacral Work ☐.

MEDICAL HISTORY: Please print clearly and fill in as completely as possible.

Have you had Chiropractic care in the past? Yes ☐ No ☐ If yes, the most recent? _____

List any Current medications, hormones, natural supplements **AND** for what reasons or diagnoses?

1._____2._____

3._____4._____

List any **allergies** to medications, substances or foods: _____ Have you taken **antibiotics** within the last 5 years? Y / N Years ago? _____ Did you take antibiotics when you were a child? Y / N Details: _____ Have you ever suffered ***TRAUMATIC*** injury (Auto wrecks, Horses, Skiing, Snowboarding, etc)? Y / N

1. Year: _____ Age: ____ Details: _____

_____

Were you evaluated and treated? Y / N Successful outcome? Y / N

2. Year:____ Age:____ Details:_____

_____

Were you evaluated and treated? Y / N Successful outcome? Y / N

Any recent ***NON-TRAMATIC*** surgeries, procedures, hospitalization or injuries? Y / N

1. Year: _____ Age: ____ Details: _____

_____

Were you evaluated and treated? Y / N Successful outcome? Y / N

2. Year:____ Age:____ Details:_____

_____

Were you evaluated and treated? Y / N Successful outcome? Y / N

Put a "✓" check mark for self and/or "P" for Parents, "S" for Sibling, "G" for Grandparent. If self please note date of diagnosis or how long you have had the condition.

__Alcoholism; Sober years? _____
__Alzheimer's Disease
__Anemia; Years? _____
__Asthma
__Autoimmune Diseases: _____
__Bronchitis
__Cancer (type): _____
__Cardiovascular Disease
__Celiac Disease
__Chronic Fatigue Syndrome
__Colitis
__Crohn's Disease
__Depression
__Diabetes; Type 1____ Type 2 ____
__Drug Abuse
__Eating Disorder _____
__Eczema
__Emphysema
__Endometriosis; Surgery/Year? _____
__Epilepsy or Seizures
__Fibromyalgia
__Genetic Disorder: _____
__Glaucoma
__Head Injury (year(s)): _____
__Hepatitis: A B C D
__High Blood Pressure
__High Cholesterol (Statin Drug? Y / N)
__HIV
__Intestinal Parasites
__Irritable Bowel Syndrome
__Kidney Disease
__Leaky Gut Syndrome
__Mental Illness
__Migraine Headaches
__Multiple Sclerosis
__Mononucleosis
__Osteoarthritis
__Osteopenia
__Osteoporosis
__Pancreatitis
__Pneumonia
__Psoriasis
__Rheumatoid Arthritis
__Skin Condition
__STD
__Stomach Ulcer
__Stroke
__Thyroid Condition _____
__Viruses? Herpes, EBV, CMV, HPV
Other: _____

PERSONAL HEALTH HISTORY:

Smoke tobacco? Never smoked ☐, Yes ☐ Per day?_____Years? _____ When quit? _____

Partake in any recreational drug activity? Y / N If so, how often per day/week? _____

Do you feel refreshed after waking up? Y/ N How old is your mattress and pillow? _____

Your sleep position(s)? _____ How many hours of Sleep per night on average? _____

Do you wake at night consistantly? What times? _____

What's the heaviest you have ever weighed? ____

Birth by C-Section ☐ or Normal ☐ Any birth trauma? _____ Were you Breastfed? Y / N

Bowel movements per day? ____ Do you have to strain? Y / N Constipation at times? Y / N
Hemorrhoids? Y / N

Are you currently taking antacids? Y / N What Type? _____ For how long? _____

What are your stressors? _____

How do you relieve stress? _____

Are you happy with your current appearance? Y / N Are you happy with your abilities? Y / N

Tell us about any Hobbies, Special Skills, and Extracurricular Activities _____

_____

Have you completed any food allergy tests? Y / N If yes, when? _____

Are you on a special diet? Y / N If yes which one(s)? _____

Have you worked with a nutritionist or health coach before? If so, how long ago and for how long?
_____ Was it helpful? Y / N

When was the last time you went to the dentist?

Do you have any history of braces, root canals, abscesses, or sub clinical infections? Please specify.

_____

YOUR PERSONAL HEALTH GOALS:

What are your personal health goals:
3 months _____
6 months _____
1 Year _____

We offer many services which may be not be part of your current course of care with us.

Would you be interested in any of the following services?

Functional Medicine ___	***Nutrition Counseling ___***	***Chronic Sinus Issues ___***
Massage Therapy ___	***Nutritional Ed. Classes ___***	***Cranial-Sacral Therapy ___***
Stress-Reduction ___	***Essential Oils Consult ___***	***Bio-Neuro Feedback ___***
Group Nutrition Classes ___		

Signature _____ Date _____

Office Use: BP ___/___ O2 Sat ___ HR ___ Height ___ Weight ___