Chiropractic Neurology & Wellness Center

New Patient Comprehensive History

Today's Date: _____
MONTH/DAY/YEAR

Date of Birth: _____ Age: _____
MONTH/DAY/YEAR

Legal Name: _____ Gender: _____

Preferred Name: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Email: _____
AREA CODE + NUMBER AREA CODE + NUMBER

Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married: Spouse's Name: _____

Please list your children and their ages:

_____ _____

_____ _____

_____ _____

_____ _____

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Student (School Name): _____

Occupation: _____

Employer: _____ Employer Phone: (_____) _____

Name/Phone Number of Emergency Contact: _____

Who referred you to our office? _____

Please list your 5 major health concerns in order of importance:

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

SLEEP HABITS

I go to bed at _____ PM. I usually have difficulty falling asleep ☐ Yes ☐ No

I frequently wake up in the middle of the night, between 1:00AM to 3:00AM ☐ Yes ☐ No

I typically wake up to start my day at _____ AM.

After waking, I usually feel… ☐ Well Rested ☐ Tired ☐ Exhausted Do you snore? ☐ Yes ☐ No

I have had a sleep study performed and the doctor diagnosed me with Sleep Apnea ☐ Yes ☐ No

The Sleep Study was performed: When? _____

by whom: _____

I use a sleep aid (C-PAP or medication): ☐ Yes ☐ No

EATING HABITS

I typically eat breakfast at _____ AM and it usually consists of _____

_____

My morning routine does/does not include cigarettes. My morning routine includes coffee. ☐ Yes ☐ No

I have a morning snack at _____ AM and it consists of _____

_____

I eat lunch at _____ PM and it consists of _____

_____

I have an afternoon snack at _____ PM and it consists of _____

_____

I eat dinner at _____ PM and it consists of _____

_____

I have an evening snack at _____ PM and it consists of _____

_____

I eat out _____ times/week. I eat fish _____ times/week. I eat raw nuts/seeds _____ times/week.

The three *worst foods* I eat during the average week _____

_____

The three *healthiest foods* I eat during the average week: _____

_____

Have you ever had a nutritional consultation? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

Describe: _____

_____

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ Dairy-Free ☐ Soy-Free

☐ Gluten-Free ☐ Vegetarian ☐ Vegan ☐ Organic

☐ Special Program for Weight Loss/Maintenance Type: _____

EATING HABITS, contd.

Daily Fluid Intake

I typically consume: _____ glasses/bottles of water daily _____ cups of tea (black/green/herbal)
_____ cups of coffee / choose one: ☐ decaf ☐ regular ☐ Starbucks's_____
_____ soft drinks (diet/decaf/regular);_____ energy drinks; _____ alcoholic beverages/week.

Daily Routine

I begin work at _____ ☐ am ☐ pm and typically finish by _____ ☐ am ☐ pm
My occupational stress level is _____ (List 1 to 10, with 0 = no stress and 10 = severe stress).
My personal stress level is _____ (List 1 to 10, with 0 = no stress and 10 = severe stress).
My exercise level is: ☐ Non-Existent ☐ Minimal (1-2 days/wk)
☐ Moderate (3-4 days/wk) ☐ Intense (5 days/wk)

Type of Exercise

☐ Walking ☐ Running ☐ Biking ☐ Weight Training ☐ Aerobic ☐ Pilates ☐ Yoga ☐ Golf
Other Exercise:_____

Currently Smoking? ☐ Yes ☐ No How many years?_____ Packs per day:_____ Attempts to quit: _____
Previous Smoking? How many years? _____ Packs per day: _____ Second-hand smoke? ☐ Yes ☐ No

SUPPLEMENTS

Please list the supplements/vitamins you currently take.

	Supplement	Dose	Frequency	Start Date	Reason
1.					
2.					
3.					
4.					
5.					
6.					

MEDICATIONS

Please list the Prescribed and Over-the-Counter medications you currently take.

	Medication	Dose	Frequency	Start Date	Reason
1.					
2.					
3.					
4.					
5.					
6.					

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No
Describe: _____

MEDICATIONS, contd.

Do you have any allergies to medications? ☐ yes ☐ no If yes, please list below.

_____

_____

Have you had prolonged or regular use of any of the following (select all that apply).

☐ NSAIDS (Advil, Aleve, Aspirin) ☐ Tylenol ☐ Allergy shots ☐ Acid Blocking Drugs (Prilosec, Zantac)

☐ Antibiotics more than 3 times/year ☐ Corticosteroids (prednisone, etc.)

Do you use creams or lotions of any kind? ☐ Facial/Eye ☐ Revitalizing ☐ Hormones

Do you use oral contraceptives? ☐ Yes ☐ No

MEDICAL HISTORY

Current Physician _____Phone _____

Have you benefitted from previous Chiropractic care? ☐ Yes ☐ No

When was your last adjustment?_____

Please list all other chiropractors/physicians/physical therapists/massage therapists you have seen for your current complaints:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Preventive Tests and Date of Last Test. Check box if yes and provide date of test.

☐ Full Physical _____ ☐ Blood Test _____ ☐ Bone Density _____

☐ Colonoscopy _____ ☐ EKG _____ ☐ Stool Test _____

☐ CT Scan _____ ☐ X-Rays _____ ☐ Upper GI Series _____

☐ Ultrasound _____ ☐ Urine _____ ☐ Cardiac Stress _____

☐ Salivary Hormones _____ ☐ Endoscopy _____ ☐ MRI _____

☐ Other: _____

Surgeries. Check box if yes and provide date of surgery

☐ Appendectomy_____ ☐ Hysterectomy +/- Ovaries _____ ☐ Gall Bladder _____

☐ Hernia _____ ☐ Tonsillectomy _____ ☐ Dental Surgery _____

☐ Joint Replacement _____ ☐ Heart Surgery _____ ☐ Angioplasty/Stent _____

☐ Pacemaker _____

☐ Other: _____

MEDICAL HISTORY, contd.

Please list and date your significant infections, traumas, and accidents.

1. _____

2. _____

3. _____

4. _____

5. _____

Environmental & Detoxification Assessment

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No

If yes, describe symptoms: _____

Do you have any adverse reaction to caffeine? ☐ Yes ☐ No

When you drink caffeine do you feel: ☐ Irritable or Wired ☐ Acne & Pains

Do you adversely react to (Check all that apply):

☐ MSG ☐ Aspartame (NutraSweet) ☐ Bananas ☐ Garlic ☐ Onion ☐ Cheese ☐ Citrus ☐ Chocolate
☐ Alcohol/Red Wine ☐ Sulfites (Wine, dried fruit, salad bars) ☐ Preservatives (i.e., sodium benzoate)
☐ Other: _____

Which of these significantly affect you? (Check all that apply):

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other: _____

ENVIRONMENTAL FACTORS

In your work or home environment, are you exposed to:

☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold ☐ Well Water

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

Have you ever been told you have Gilbert's Syndrome or a Liver Disorder? ☐ Yes ☐ No

Explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as:

☐ Herbicides ☐ Insecticides/Pesticides ☐ Organic Solvents ☐ Heavy Metals

Chemical name, date, & length of exposure:_____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Have you lived or worked in a damp or moldy environment or had other mold exposures? ☐ Yes ☐ No

Do you have any pets or farm animals? ☐ Yes ☐ No

Review of Symptoms: (Please check all boxes that apply)

General

☐ Cold Hands & Feet	☐ Cold Intolerance	☐ Low Body Temp	☐ Low Blood Pressure
☐ Daytime Sleepiness	☐ Difficulty Falling Asleep	☐ Early Waking	☐ Fatigue
☐ Fever	☐ Flushing	☐ Heat Intolerance	☐ Night Walking
☐ Nightmares	☐ No Dream Recall		

Head, Eyes & Ears

☐ Conjunctivitis	☐ Distorted Sense of Smell	☐ Distorted Taste	☐ Ear Fullness
☐ Ear Pain	☐ Ear Ringing/Buzzing	☐ Lid Margin Redness	☐ Eye Crusting
☐ Eye Pain	☐ Hearing Loss	☐ Hearing Problems	☐ Headache
☐ Migraine	☐ Sensitivity to Loud Noises	☐ Vision Problems (other than glasses)	
☐ Macular Degen.	☐ Vitreous Detachment	☐ Retinal Detachment	

Musculoskeletal

☐ Back Muscle Spasm	☐ Calf Cramps	☐ Chest Tightness	☐ Foot Cramps
☐ Joint Deformity	☐ Joint Pain	☐ Joint Redness	☐ Joint Stiffness
☐ Muscle Pain	☐ Muscle Spasm	☐ Muscle Stiffness	☐ Muscle Weakness
☐ Tension Headaches	☐ TMJ Problems	☐ Neck Muscle Spasm	☐ Tendonitis
☐ Muscle Twitch Around Eyes		☐ Muscle Twitch Arms or Legs	

Mood/Nerves

☐ Agoraphobia	☐ Anxiety	☐ Black-outs	☐ Depression
☐ Dizziness	☐ Vertigo	☐ Fainting	☐ Fearfulness
☐ Irritability	☐ Light-Headedness	☐ Numbness	☐ Other Phobias
☐ Panic Attacks	☐ Paranoia	☐ Seizures	☐ Suicidal Thoughts
☐ Tingling	☐ Tremor/Trembling	☐ Visual or Auditory Hallucinations	

SYMPTOM HISTORY

Difficulty with…

☐ Concentrating ☐ Balance ☐ Thinking ☐ Judgment ☐ Speech ☐ Memory

Digestion

☐ Anal Spasms ☐ Bad Teeth ☐ Bleeding Gums ☐ Oral Blisters
☐ Blood in Stools ☐ Burping ☐ Canker Sores ☐ Cold Sores
☐ Cracking at the corners of lips ☐ Cramps ☐ Heartburn
☐ Dentures ☐ Diarrhea ☐ Fissures ☐ Nausea
☐ Dry Mouth ☐ Excess Flatulence/gas
☐ Hemorrhoids ☐ Indigestion ☐ Sore Tongue ☐ Difficulty Swallowing
☐ Vomiting ☐ Alternating Diarrhea/Constipation ☐ Periodontal Disease
☐ Constipation ☐ Lower Abdominal Pain ☐ Upper Abdominal Pain
☐ Strong Stool Odor ☐ Undigested Food in Stool ☐ Mucus in Stools

Bloating of …

☐ Lower Abdomen ☐ Whole Abdomen ☐ Bloating after meals

Intolerance to …

☐ Lactose ☐ All Dairy Products ☐ Gluten ☐ Corn
☐ Eggs ☐ Soy ☐ Fatty Foods ☐ Yeast

Skin Problems …

☐ Acne on Back ☐ Acne on Chest ☐ Acne on Face ☐ Acne on Shoulders
☐ Athlete's Foot ☐ Bumps on Back of Upper Arms ☐ Dark Circles under eyes
☐ Cellulite ☐ Ears get cold ☐ Easily Bruise ☐ Lack of Sweating
☐ Too Much Sweating ☐ Eczema ☐ Hives ☐ Jock Itch
☐ Lackluster Skin ☐ Moles w/Color/Size Changes ☐ Oily Skin
☐ Pale Skin ☐ Patchy Dullness ☐ Rash ☐ Red Face
☐ Sensitivity to Bites ☐ Shingles ☐ Sensitivity to Poison Ivy/Oak
☐ Skin Darkening ☐ Strong Body Odor ☐ Hair Loss ☐ Vitiligo

Itchy Skin…

☐ Skin in General ☐ Anus ☐ Arms ☐ Ear Canals
☐ Eyes ☐ Feet ☐ Hands ☐ Legs
☐ Nipples ☐ Nose ☐ Penis ☐ Roof of Mouth
☐ Scalp ☐ Throat

Dryness of …

☐ Eyes ☐ Feet ☐ Hands (Cracks or Peel)
☐ Hair ☐ Mouth/Throat ☐ Scalp (Dandruff) ☐ Skin in General

SYMPTOM HISTORY, contd.

Lymph Nodes

☐ Enlarged/Tender Neck ☐ Enlarged/Tender Axilla ☐ Enlarged/Tender Groin

Nails

☐ Bitten	☐ Brittle	☐ Curved Up	☐ Frayed
☐ Fungus- Fingers	☐ White Spots/Lines	☐ Pitting	☐ Ragged Cuticles
☐ Ridges	☐ Soft	☐ Thickening of Fingernails or Toenails	

Respiratory

☐ Bad Breath	☐ Bad Odor in Nose	☐ Cough-Dry	☐ Cough – Productive
☐ Hoarseness	☐ Sore Throat	☐ Hay Fever	☐ Nasal Stuffiness
☐ Nose Bleeds	☐ Post Nasal Drip	☐ Sinus Fullness	☐ Sinus Infection
☐ Snoring	☐ Wheezing	☐ Winter Stuffiness	

Cardiovascular

☐ Angina/Chest Pain	☐ Shortness of Breath	☐ Heart Murmur	☐ Irregular Pulse
☐ Palpitations	☐ Phlebitis	☐ Swollen Ankles/Feet	☐ Varicose Veins

Urinary

☐ Bed Wetting	☐ Hesitancy	☐ Infection	☐ Kidney Disease
☐ Leaking/Incontinence	☐ Pain/Burning	☐ Urgency	

Chiropractic Neurology & Wellness Center

Family Medical History

Check all that apply	Mother	Father	Brother	Sister	Children	Mother's Parents	Father's Parents	Aunts & Uncles
Ages						NA	NA	NA
Cancers	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Psoriatic Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hoshimoto's Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐
Lupus (SLE)	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Environmental Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Psoriasis/Eczema	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐	☐	☐	☐
ALS	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disease	☐	☐	☐	☐	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐	☐
Other								
Other								

Patient Health Information

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Chiropractic Neurology & Wellness Center (CNWC) to use their patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by CNWB to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature:_____ Date: _____

Patient's Name:_____
PLEASE PRINT

Chiropractic Neurology & Wellness Center

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now or in the future render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications that may arise during a Chiropractic adjustment. Those complications may include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costrovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments, and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Chiropractic Neurology & Wellness Center
618 Frederick St., Santa Cruz, CA 95062
831-460-9200

Name of Doctor Treating this Patient
James M. Cartwright, D.C., D.A.C.N.B.
www.cartwrightwellnes.com

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient	Date
Signature of Patient	Date
Signature of Patient's Representative	Date
Witness Signature	Date

Chiropractic Neurology & Wellness Center

FINANCIAL POLICY

All fees are based on individual services rendered, and may vary from visit to visit, depending on the doctor's treatment recommendations.

It is our office policy to maintain your account on a current basis. Charges for treatment are due at the time the service is provided. Any balance that incurs on your account is subject to an interest charge of 10% per month, until paid to a zero balance.

We require a 48-hour notice for ALL cancellations. You will be charged the full amount of your scheduled visit if changes are made within this 48-hour limit. We require that all patients store a credit card on file for any missed appointment fees; however no other charges will be made unless the account becomes past due for a period of 30 days or more.

INSURANCE/IN NETWORK: if you have health insurance, we will verify your coverage; but you are responsible for paying your deductible, co-payments, and non-covered charges, *AT THE TIME THEY ARE RENDERED.* We do not guarantee that all services will be covered by your insurance. We will gladly bill your insurance once, however if they fail to pay within 45 days of billing, you will be responsible for the amount due in full.

NON-INSURED/OUT OF NETWORK: All visits must be paid for *AT THE TIME OF SERVICE* . Any other financial arrangements must be determined prior to services rendered.

MEDICARE: Manipulation is the ONLY service covered by Medicare. You are responsible for payment of the initial visit (call our office for current rate), your annual deductible with Medicare, co-payments, and any other services, *AT THE TIME OF SERVICE*.

****If you have been involved in a motor vehicle accident, we can NOT bill Medicare for services related to your accident.**

In the event that there is an outstanding balance, which fails to be cured within sixty (60) days, my account with Chiropractic Neurology & Wellness Center may be turned over to collections. I understand that should this occur, I will remain responsible for any and all additional collection fees and/or attorney and court costs.

I agree to the terms of this agreement.

Signature:_____ Date:_____

Printed name:_____