



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. _____



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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: _____



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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: _____



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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.

- | | | |
|--|---|--|
| <input type="checkbox"/> Full Physical _____ | <input type="checkbox"/> Blood Test _____ | <input type="checkbox"/> Bone Density _____ |
| <input type="checkbox"/> Colonoscopy _____ | <input type="checkbox"/> EKG _____ | <input type="checkbox"/> Stool Test _____ |
| <input type="checkbox"/> CT Scan _____ | <input type="checkbox"/> X-Rays _____ | <input type="checkbox"/> Upper GI Series _____ |
| <input type="checkbox"/> Ultrasound _____ | <input type="checkbox"/> Urine _____ | <input type="checkbox"/> Cardiac Stress _____ |
| <input type="checkbox"/> Salivary Hormones _____ | <input type="checkbox"/> Endoscopy _____ | <input type="checkbox"/> MRI _____ |
| <input type="checkbox"/> Other: _____ | | |

Surgeries. Check box if yes and provide date of surgery

- | | | |
|--|---|--|
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Hysterectomy +/- Ovaries _____ | <input type="checkbox"/> Gall Bladder _____ |
| <input type="checkbox"/> Hernia _____ | <input type="checkbox"/> Tonsillectomy _____ | <input type="checkbox"/> Dental Surgery _____ |
| <input type="checkbox"/> Joint Replacement _____ | <input type="checkbox"/> Heart Surgery _____ | <input type="checkbox"/> Angioplasty/Stent _____ |
| <input type="checkbox"/> Pacemaker _____ | | |
| <input type="checkbox"/> Other: _____ | | |



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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: _____



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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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Cold Hands & Feet | <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Low Body Temp | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Daytime Sleepiness | <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Early Waking | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Flushing | <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Night Walking |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> No Dream Recall | | |

Head, Eyes & Ears

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Conjunctivitis | <input type="checkbox"/> Distorted Sense of Smell | <input type="checkbox"/> Distorted Taste | <input type="checkbox"/> Ear Fullness |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Ear Ringing/Buzzing | <input type="checkbox"/> Lid Margin Redness | <input type="checkbox"/> Eye Crusting |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Sensitivity to Loud Noises | <input type="checkbox"/> Vision Problems (other than glasses) | |
| <input type="checkbox"/> Macular Degen. | <input type="checkbox"/> Vitreous Detachment | <input type="checkbox"/> Retinal Detachment | |

Musculoskeletal

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Back Muscle Spasm | <input type="checkbox"/> Calf Cramps | <input type="checkbox"/> Chest Tightness | <input type="checkbox"/> Foot Cramps |
| <input type="checkbox"/> Joint Deformity | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Joint Redness | <input type="checkbox"/> Joint Stiffness |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Muscle Spasm | <input type="checkbox"/> Muscle Stiffness | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Tension Headaches | <input type="checkbox"/> TMJ Problems | <input type="checkbox"/> Neck Muscle Spasm | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Muscle Twitch Around Eyes | | <input type="checkbox"/> Muscle Twitch Arms or Legs | |

Mood/Nerves

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Agoraphobia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Black-outs | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fearfulness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Light-Headedness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Other Phobias |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Tremor/Trembling | <input type="checkbox"/> Visual or Auditory Hallucinations | |



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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



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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



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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	<input type="checkbox"/>							
Heart Disease	<input type="checkbox"/>							
High Blood Pressure	<input type="checkbox"/>							
Obesity	<input type="checkbox"/>							
Diabetes	<input type="checkbox"/>							
Stroke	<input type="checkbox"/>							
Rheumatoid Arthritis	<input type="checkbox"/>							
Psoriatic Arthritis	<input type="checkbox"/>							
Celiac Disease	<input type="checkbox"/>							
Hoshimoto's Disease	<input type="checkbox"/>							
Hypothyroidism	<input type="checkbox"/>							
Multiple Sclerosis	<input type="checkbox"/>							
Lupus (SLE)	<input type="checkbox"/>							
Asthma	<input type="checkbox"/>							
Food Allergies	<input type="checkbox"/>							
Environmental Allergies	<input type="checkbox"/>							
Psoriasis/Eczema	<input type="checkbox"/>							
Parkinson's Disease	<input type="checkbox"/>							
ALS	<input type="checkbox"/>							
Dementia	<input type="checkbox"/>							
Depression	<input type="checkbox"/>							
Bipolar Disease	<input type="checkbox"/>							
ADD/ADHD	<input type="checkbox"/>							
Autism	<input type="checkbox"/>							
Substance Abuse	<input type="checkbox"/>							
Genetic Disorders	<input type="checkbox"/>							
Scoliosis	<input type="checkbox"/>							
Other								
Other								



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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



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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 costovertebral 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
545 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 (\$195), 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: _____

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.