Essence of Wellness.com

REACTIVATION
Patient Information

Name _____ Date_____ Email _____
Address _____City_____State_____Zip_____
Home phone _____ Work phone _____ Cell _____
Your employer _____ Occupation_____

Type of claim: □ Cash □ Group Health Insurance □ Auto / Personal Injury □ Worker's Comp □ Medicare □ Medicaid

Primary —*please present card to receptionist.*
Insurance _____ Primary Insured Name _____
Policy #_____Date of Birth _____/_____/_____
Address if different than patient_____
Secondary —*please present card to receptionist.*
Insurance _____ Primary Insured Name _____
Policy #_____Date of Birth _____/_____/_____
Address if different than patient_____

What is your preferred communication? □ In person □ US mail □ E-mail □ Cell phone □ Home phone □ Work phone □ Other _____
May we leave you a message on your machine or with someone ? Y / N If yes, who? _____
What type of message may we leave? □ only ask to return call □ appointment information only □ any detail necessary
Smoking Status? □ Former Smoker: stop date_____ □ Current every day: Start Date_____ □ Current some days
Do you have any medication allergies? Y / N Which?_____
Are you currently taking any medications? Y / N Please List or Provide a List: _____
_____

1. Please underline all of the following symptoms you have had <u>previously</u>. Please circle all of the following conditions you have now

Anxiety	Cold Hands	Difficulty Swallowing	Impotence	Mood Swings
Abdominal Pain	Cold Sweats	Dizziness	Incontinence	Nervousness
Appetite Change	Concentration Loss	Enlarged Glands	Insomnia	Poor Circulation
Bed-Wetting	Confusion	Face flushed	Light Sensitivity	Ringing in Ears
Black Tarry Stools	Concussion	Fainting	Loss of Balance	Skin/Hair/Nail Changes
Blurred Vision	Constipation (Excess)	Fatigue (Recent)	Loss of Bowel Control	Sinus Trouble
Breast Lumps/Pain	Diarrhea (Excess)	Fever (Recent)	Loss of Smell	Swelling
Bruise Easily	Difficulty Breathing	Frequent Illness	Loss of Taste	Urination Painful/Frequent
Chills	Difficulty Hearing	Heartburn	Memory Loss	Vomiting
Cold Feet	Difficulty Seeing	Hernias	Menstrual Discomfort	Weight Change

2. Please indicate if you or any immediate family member (parent, grandparent or sibling) has experienced the following conditions. Y= you F=family member. Please identify your relationship to the family member on the side

Y	F		Y	F		Y	F		Y	F	
□	□	AIDS	□	□	Digestive Disorder	□	□	Irritable Bowel	□	□	Rheumatic Fever
□	□	Allergies	□	□	Epilepsy	□	□	Kidney Disorders	□	□	Rheumatism
□	□	Anemia	□	□	Fibromyalgia	□	□	Liver Disease	□	□	Scarlet Fever
□	□	Autoimmune Dis	□	□	Gallbladder Disease	□	□	Lung Disease	□	□	Scoliosis
□	□	Bleeding Disorder	□	□	German Measles	□	□	Multiple Sclerosis	□	□	Stroke
□	□	Bladder Trouble	□	□	Gout	□	□	Muscular Dystrophy	□	□	Tremors
□	□	Cancer	□	□	Heart Disease	□	□	Osteoporosis	□	□	Thyroid Problems
□	□	Convulsions	□	□	Hepatitis	□	□	Paralysis	□	□	Tuberculosis
□	□	Depression	□	□	High Blood Pressure	□	□	Phobias	□	□	Ulcers
□	□	Diabetes	□	□	High Cholesterol	□	□	Polio	□	□	Venereal Disease
			□	□	HIV/ARC	□	□	Reproductive Issue	□	□	Other:_____
											___

A. COMPLAINTS/CONCERNS

1. Please list your main health objectives or chief complaints.

_____

When did you first notice this?_____Describe what the condition feels like_____
What do you do for relief? _____
Did something happen?_____

_____

2. When are your symptoms worse? ☐Morning ☐Afternoon ☐Evening ☐Night ☐Always the same

3. How did your complaint(s) begin? ☐Unknown ☐Suddenly ☐Gradually

4. Check all the appropriate descriptions.

The sensations I feel are:

Pain	Numbness	Tingling	Stiffness	Soreness	Swelling
☐	☐	☐	☐	☐	☐

The quality of the pain is:

Burning	Dull	Sharp	Shooting	Aching	Throbbing
☐	☐	☐	☐	☐	☐

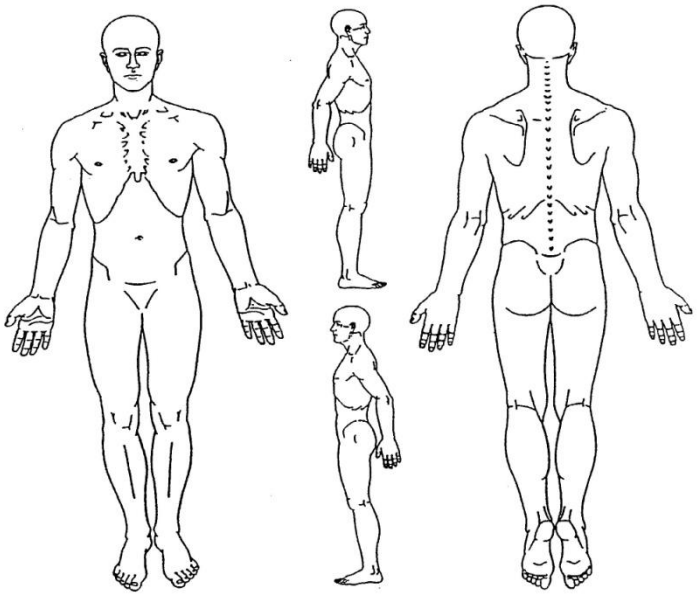
The pain duration is:

Occasional	Intermittent	Frequent	Constant
☐	☐	☐	☐

My condition is:

Improving	Worsening	Unchanged	Resolved
☐	☐	☐	☐

5. Indicate on the diagram where you have your complaints.



6. Mark what makes your condition Better or Worse?

☐B ☐W	☐B ☐W	☐B ☐W
☐ ☐ Bending	☐ ☐ Looking Down	☐ ☐ Rest
☐ ☐ Exercise	☐ ☐ Lying Down	☐ ☐ Sitting
☐ ☐ Heat	☐ ☐ Medication	☐ ☐ Standing
☐ ☐ Ice	☐ ☐ Nothing	☐ ☐ Stretching
☐ ☐ Lifting	☐ ☐ Pull/Pushing	☐ ☐ Twisting
☐ ☐ Looking Up	☐ ☐ Reaching	☐ ☐ Walking
☐ **Laughing**	☐ **Coughing**	☐ **Straining At Stool**

7. Have you noticed a change in?

☐ Bowel Function ☐ Bladder Function ☐ Coordination
☐ Sexual Function ☐ Muscular Strength

8. On a scale of 0- 10 rate the severity of your pain today.

If your pain fluctuates please indicate approximately the % of time at each pain level. *Example* 0 1 2 ③ 4 5 6 7 ⑧ 9 10

							70%		30%		
	No Pain										Worst Pain Possible
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

9. What happened to cause or re-aggravate your complaint(s)?

☐Cause Unknown ☐Auto Accident ☐Personal Injury
☐Work Injury ☐Home Accident ☐Sport Injury
☐Other – Describe: _____

10. Please circle all areas of previous or current complaints or injuries.

Neck	Uppr back	Mid Back	Low Back	Shoulder	Arm	Elbow	Forearm	Wrist
Hand/Finger	Buttock	Hip	Thigh	Knee	Leg/Calf	Ankle	Foot	Others: