# Achieving Wellness Chiropractic Center LLC Dr. Kerri Ward 304 N.W. Bethany Dr. Port St. Lucie. FL 34986 772-344-1431

### **New Patient Questionnaire**

Date						
Name	Preferred name					
Address						
City/State/Zip						
Phone # s (home)	(cell)	**************************************				
Email address	Birthdate	Birthdate				
Occupation	Employer					
Is it okay to contact you at work? Yes	No V	Vork #				
Marital Status: single married	separated	divorced	widowed			
Spouse's name	Phone #	(s)				
Children's names and ages						
Favorite hobbies or interests						
Emergency contact: Name:						
Relationship	Phone N	umber # (s)				
What Brings You Here?						
Have you ever had chiropractic care before?	Yes	No	*			
If yes, please tell us with who		Phone #				
Were you pleased with your care?	Yes	No				
How did you find out about our office?						
Is this appointment related to: work sports	s auto po	ersonal injury other	er			
If this visit is related to an auto accident plea	ase fill out an aut	o accident form.				
When did the incident occur?						
Attorney (if applicable)						
Are you receiving care from other health profess						
Primary Care Doctor(s)						
Are you under the care of any other specialist?						

Please list all drugs or medications you are taking
Please list all vitamins/herbs/homeopathics/other you are taking
Are you pregnant?
Yes No If yes, how many weeks? Due Date?:
Current Health
What are your pressing health concerns?
How long have you experienced this problem?
Is it: getting worse improving intermittent constant can't say
Where is the problem? Please use the illustrations and lines below to explain. N (numbness) X (pain) T (tingling)
FrontBack
What makes this problem worse?
What makes this problem better?
Do you have: pain numbness tingling aches
Is your pain: sharp dull throbbing constant intermittent
Rate your pain on scale from 1-10 (1 least,10 most)
Are your symptoms affected by? sitting standing walking bending lying down weather other
Please explain

#### **HEALTH HISTORY**

DO YOU OR ANY FAMILY MEMBER HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING? (CIRCLE ALL THAT APPLY AND NOTATE WHO (I) FOR YOURSELF, (F) FOR FATHER, (M) FOR MOTHER, (B) FOR BROTHER, (S) FOR SISTER ON LINE BEFORE ISSUE) HEADACHE MIGRANES DIZZINESS BLURRED VISION **NECK PAIN** EAR PAIN DIFFICULTY HEARING DENTAL PROBLEMS JAW PAIN/TMJ SINUS CONGESTION DIFFICULTY BREATHING PLEURISY \_\_\_COPD \_\_\_\_HAND PAIN/TINGLING SHOULDER PAIN ARM PAIN/TINGLING ABNORMAL BLOOD PRESSURE HEART PROBLEMS CHEST PAIN HEART DISEASE BREAST PAIN/LUMP IRREGULAR HEARTBEAT WEIGHT LOSS \_\_\_HEARTBURN IRRITABLE BOWEL CONSTIPATION HEMORRHOIDS BLACK OR BLOODY STOOL POOR APPETITE EXCESSIVE APPETITE \_\_\_\_ANEMIA GAS/BLOATING AFTER MEALS FAINTING STROKE ASTHMA NUMBNESS \_\_\_\_LIVER PROBLEMS \_\_\_\_\_PARALYSIS FREQUENT NAUSEA \_\_\_\_COLITIS LOW BACK PAIN HERNIATED DISK CRAMPS URINARY URGENCY PAINFUL URINATION EXCESSIVE URINATION DISCOLORED URINE RASHES COLD EXTREMITIES DIABETES THYROID DISEASE PROSTATE PROBLEMS CONFUSION CHRONIC FATIGUE NERVOUSNESS LOSS OF SLEEP SHINGLES POLIO MUMPS CHICKENPOX **MEASLES** PNEUMONIA \_\_\_\_EPILEPSY OSTEOPOROSIS INFLUENZA \_\_\_\_HIV/AIDS KIDNEY DISEASE LEUKEMIA \_\_\_ANXIETY ARTHRITIS /RHEUMATOID ADHD/ADD DEPRESSION SCHIZOPHRENIA PTSD SCIATICA ANKLE SWELLING RHUEMATIC FEVER CANCER /TYPE \_\_\_ALLERGIES/TYPE\_\_\_\_\_ IF YOU HAVE EVER BEEN DIAGNOSED WITH ANOTHER DISEASE OR CONDITION, PLEASE DESCRIBE DO YOU DRINK: COFFEE TEA ALCOHOL SODA ENERGY DRINKS

DO YOU USE: CIGARETTES

COLLE

RECREATIONAL DRUGS

**ARTIFICIAL SWEETENERS** 

**SUGAR** 

#### falls/accidents head injures fights surgery broken bones dislocation spinal tap sports injuries traction extensive dental work dental applications knocked unconscious used cane or walker other\_\_\_\_\_ If yes to any of the above, please describe\_\_\_\_\_\_ **Stress History** All stress can cause or contribute to subluxations. To better understand your health and well-being it is important that we review your stress history. Don't know Have you been vaccinated with childhood vaccines? Yes No Which one?\_\_\_\_\_ No Have you received Covid-19 vaccine? Yes achiness Did you have vaccine reactions? swelling at injection site fever Have you had extensive dental work, orthodontic or jaw problems? Yes No Do you have a astigmatism or other visual problems? Yes No Yes No Do you wake up refreshed? How old is your mattress? \_\_\_\_\_years **Lifestyle Stresses** On a scale of 1-10(1 least, 10 most) please rate: Your **stress** from: 3 5 6 7 9 10 1 2 Work/School 6 7 8 9 10 3 5 2 Family Relationships 1 5 6 8 9 10 2 3 7 1 Loss of loved one(s) 5 6 7 8 9 10 2 3 1 Health problems 1 2 3 5 6 7 8 9 10 3 5 6 7 8 9 10 2 Your physical health 1 10 1 2 3 5 6 7 8 9

5

6

3

2

1

7

8

9

10

Past injures can affect present health (please circle all that apply)

Your emotional health

Your spiritual health

Your satisfaction with:										
Work	1	2	3	4	5	6	7	8	9	10
Family relationships	1	2	3	4	5	6	7	8	9	10
Achievements	1	2	3	4	5	6	7	8	9	10
Other	1	2	3	4	5	6	7	8	9	10
Your current overall stress le	vel 1	2	3	4	5	6	7	8	. 9 .	10
Is your stress constant?	Yes	No	Pleas	e explai	n	and another the analysis and the		samunistanun (animair)	···	nancesca compact the compa
Do you think any aspects of you	ur lifesty	yle conti	ribute to	your he	alth pro	blems?				
Yes No Please explain	***************************************	Karanian adaptar ang kalanda kantan kant			ngoni wanana waki nasi sa sarsi	al anticipi anni da color no al constitución con consti	anal-characture to envenoerous services	e) wiesseuroosse vineken voorse stroet van	CONTRACTOR OF THE PROPERTY OF	Sapoteorofia otto se setal televidik
Describe your eating habits. Do	you ea	ıt 3-5 s∈	ervings o	f fruits o	r veget	ables a	day?	Yes		No
If not, how many?	torritore to respect to the construction.	How m	any glas	ses of v	vater do	you dri	nk daily	2	Caratani en Principal (consensora	1000-100 (1000-1000 (100) (1000 (100) (1000 (100) (1000 (100) (1000 (100) (1000 (100) (1000 (100) (100) (1000 (100) (100) (1000 (100) (100
Are you presently (or have you	been) a	active in	any spo	orts or ex	kercise'	?		Yes		No
Which one (s)?				ani ni mangkan kan katalan na sairi ka		prijani ngati nina kanceriannian manan	Dating in all restrictions and instructions in	alare) sagreine la la constante		
Have you been hurt exercising	or playi	ng?						Yes		No
If yes, age at the time and injur	У	*****************************	povečnenia kraji poposa proposa kraji na kraji poposa	en anno ann ann ann ann ann ann ann ann a	ancidad contract contract contract contract contracts contract contracts contract contracts contracts contract contracts contr	and the second seco	instruments and a second second second second second second	ante s rimenspanentias con massiverance de	nio qual derrati saling l'adactivante à bin had cervi (	recinentesimon contributorio (chi babbano
Do any family members have s	imilar p	roblems	s to your:	s? Yes	No	explain	e • sancerstansierne/ultregen/sessione	isaanteum oo bhine isaatteeri nec'hook	nai nagoran kristolian erhakila kisila kananasi.	suumi (ssuransississississississississississississis
What do you know abou	ıt chire	opract	ic?							
In your own words, what do chi		-		5.1						
*			Ann and the colonial an		nige conscious particular consciou		al-wollenger), Charles in victoria (Charles) in vigitari	The Control of the Co		Tendos au montuma de la comercia
Do you know what a subluxation	on is?	<del></del>	a rational and a separate representative and a separate representa		ad raccorrespondent trade Colonical	rgum Neduculova subupa luginu subbecto pada		Yes	300000000000000000000000000000000000000	No
Maria alama dan alba										
If yes, please describe										
Are you seeking chiropractic fo		aintena	nce/ opt	imizatio	n	heal	th proble	ems		both
Are you seeking chiropractic fo	or m									both
Are you seeking chiropractic fo	r m	practic o	care?	reservations and principles and a secondary was	nationinus au jeznámai conict piece	aniem) seal ellen (Strett sconit en l'anna	ing i an ing allangang beneral basas			both
Are you seeking chiropractic fo	or mom chiro	practic o	care?	like us	to know	about y	ou?	Yes		astra i dan se sangan ang mangkana na matang

## Financial Responsibility

Who is responsible for payment?			
How will you pay for your care?	Cash	Check	Credit Card
Medicare #			s 4
Secondary Insurance Co			<del>-</del>
Policy #			
Subscriber's Name		_ Subscriber's	Date of Birth
Relationship to you			
Is this an auto accident? Yes	No		
If yes, who is the policy holder?			
Auto Insurance Co.			· · · · · · · · · · · · · · · · · · ·
Claim #			
Attorney (if applicable)			
Phone #			
Insurance verification and authoriz	ation is	not a guarar	ntee of payment.
I understand that I may be response authorize Achieving Wellness Chirolinformation regarding my treatmer reimbursement for services provide submissions. The above is accurate	opractic nt to an	Center LLC/ L by insurance of thorize the us	Or. Kerri Ward to release any company in effort to receive e of my signature in all insurance
	*		
(SIGNATURE)			(Date)