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 _____ Age_____

Occupation _____ Employer _____

Is it okay to contact you at work? Yes No Work # _____

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 Number # (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 auto personal injury other _____

If this visit is related to an auto accident please fill out an auto accident form.

When did the incident occur?_____

Attorney (if applicable) _____ Phone # _____

Are you receiving care from other health professionals? Yes No

Primary Care Doctor(s) _____

Are you under the care of any other specialist? Yes No Names:_____

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? _____

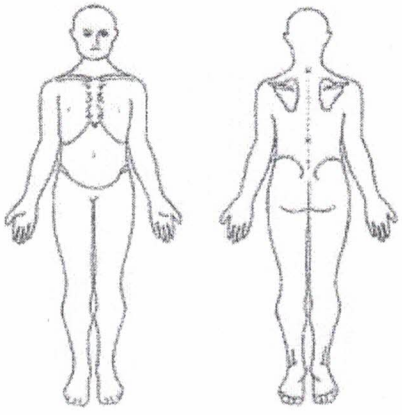
_____

_____

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)



Front _____ Back _____

_____ _____

_____ _____

_____ _____

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	_____SHOULDER PAIN	_____ARM PAIN/TINGLING	_____HAND PAIN/TINGLING
_____CHEST PAIN	_____HEART PROBLEMS	_____HEART DISEASE	_____ABNORMAL BLOOD PRESSURE
_____HEARTBURN	_____BREAST PAIN/LUMP	_____IRREGULAR HEARTBEAT	_____WEIGHT LOSS
_____IRRITABLE BOWEL	_____CONSTIPATION	_____HEMORRHOIDS	_____BLACK OR BLOODY STOOL
_____POOR APPETITE	_____EXCESSIVE APPETITE	_____ANEMIA	_____GAS/BLOATING AFTER MEALS
_____STROKE	_____FAINTING	_____ASTHMA	_____NUMBNESS
_____LIVER PROBLEMS	_____PARALYSIS	_____FREQUENT NAUSEA	_____COLITIS
_____LOW BACK PAIN	_____HERNIATED DISK	_____CRAMPS	_____ URINARY URGENCY
_____ RASHES	_____PAINFUL URINATION	_____EXCESSIVE URINATION	_____DISCOLORED URINE
_____ DIABETES	_____THYROID DISEASE	_____COLD EXTREMITIES	_____PROSTATE PROBLEMS
_____CONFUSION	_____NERVOUSNESS	_____CHRONIC FATIGUE	_____LOSS OF SLEEP
_____POLIO	_____MUMPS	_____CHICKENPOX	_____SHINGLES
_____MEASLES	_____PNEUMONIA	_____EPILEPSY	_____OSTEOPOROSIS
_____INFLUENZA	_____HIV/AIDS	_____KIDNEY DISEASE	_____LEUKEMIA
_____ANXIETY	_____ADHD/ADD	_____DEPRESSION	_____ARTHRITIS /RHEUMATOID
_____PTSD	_____SCHIZOPHRENIA	_____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 RECREATIONAL DRUGS ARTIFICIAL SWEETENERS SUGAR

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

falls/accidents head injures fights surgery

sports injuries broken bones dislocation spinal tap

knocked unconscious traction dental applications extensive dental work

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.

Have you been vaccinated with childhood vaccines? Yes No Don't know

Have you received Covid-19 vaccine? Yes No Which one?_____

Did you have vaccine reactions? swelling at injection site fever achiness

Other_____

Have you had extensive dental work, orthodontic or jaw problems? Yes No

Do you have a astigmatism or other visual problems? Yes No

Do you wake up refreshed? Yes No

How old is your mattress? _____years

Lifestyle Stresses

On a scale of 1-10(1 least, 10 most) please rate:
Your **stress** from:

Work/School	1	2	3	5	6	7	8	9	10
Family Relationships	1	2	3	5	6	7	8	9	10
Loss of loved one(s)	1	2	3	5	6	7	8	9	10
Health problems	1	2	3	5	6	7	8	9	10
Other_____	1	2	3	5	6	7	8	9	10
Your physical health	1	2	3	5	6	7	8	9	10
Your emotional health	1	2	3	5	6	7	8	9	10
Your spiritual health	1	2	3	5	6	7	8	9	10

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 level	1	2	3	4	5	6	7	8	9	10

Is your stress constant? Yes No Please explain _____

Do you think any aspects of your lifestyle contribute to your health problems?

Yes No Please explain _____

Describe your eating habits. Do you eat 3-5 servings of fruits or vegetables a day? Yes No

If not, how many? _____ How many glasses of water do you drink daily?_____

Are you presently (or have you been) active in any sports or exercise? Yes No

Which one (s)? _____

Have you been hurt exercising or playing? Yes No

If yes, age at the time and injury _____

Do any family members have similar problems to yours? Yes No explain:_____

What do you know about chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what a subluxation is? Yes No

If yes, please describe _____

Are you seeking chiropractic for maintenance/ optimization health problems both

What would you like to gain from chiropractic care? _____

Are there other health concerns or anything else you'd like us to know about you? Yes No

If yes, please tell us _____

_____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care? Cash Check Credit Card

Medicare # _____

Secondary Insurance Co. _____

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 authorization is not a guarantee of payment.

I understand that I may be responsible for any balance that is not paid by insurance. I authorize Achieving Wellness Chiropractic Center LLC/ Dr. Kerri Ward to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of my signature in all insurance submissions. The above is accurate to the best of my knowledge.

_____ _____

(SIGNATURE) (Date)