



Dr. Gerard Rosney - Dr. Joseph Rosney

New Patient Health Information Form

Date: _____

Name: _____ DOB: _____ Age: _____ Sex: M / F

Home Phone # _____ Cell # _____ Work # _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Marital Status: M / S / D / W Children: Y / N Ages: _____

Who may we thank for referring you? _____

Your hobbies: _____

Do you exercise? Y / N How often? _____ What type? _____

Diet: Healthy / Ave / Poor Vitamins/supplements? Y / N Alcohol: Never/Rare/Moderate/Daily

Have you consumed alcohol in the last 24 hours: Y / N When? _____

Smoker: Y / N Packs per day: _____ How Long: _____ Past Smoker Y / N Date Quit: _____

Occupation: _____ Employer: _____

Insurance Company: _____ Policy #: _____

Spouse's name: _____ Spouse's DOB: _____

Occupation: _____ Employer: _____

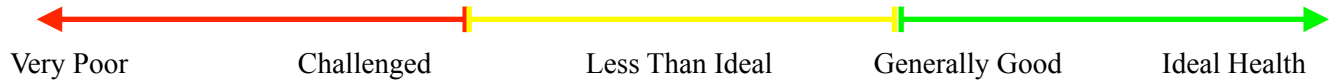
Insurance Company: _____ Policy # _____

Treatment and Finances: First and foremost the priority in this office is to provide the highest quality of care to all patients. As a courtesy our office will provide each patient with a detailed invoice that can be submitted to insurance for reimbursement directly *from your insurance company to you*. Please be sure to let us know if you would like an invoice. Though we are happy to provide you with this, it is our policy to collect payment in the office at the time of service.

I understand that payment is due at time of service and as a courtesy this office will provide me with a detailed invoice that may be submitted to my insurance company.

I have questions about this policy or have other financial related concerns and would like to speak to someone in the office about this.

As a society we are ranked 50th in the world when it comes to health, but at TLC Chiropractic Wellness Center we take pride in helping people to reach their optimum health and wellness. In order to help you best, we would like an honest assessment of where you believe your current level of health is. So please place an “X” on the scale below marking where you believe your level of health and wellness is at this time. Then place a circle “O” on the diagram indicating where you would like your health and wellness to be.



Patient Health Profile

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or concerns and are here for Chiropractic Wellness Services, please skip to the “General History” page.

Primary Health Concern: _____

When did your health challenge start? _____ Is it getting worse? Yes / No

How often are you in pain? _____ Is it constant? Yes / No

Rate the severity of your pain on a scale from 1 (least) to 10 (severe):

Current Today _____ Worst Ever _____ Average _____

Type of pain: (circle all that apply)

Sharp / Dull / Throbbing / Numbness / Aching / Shooting / Burning / Tingling

Cramps / Stiffness / Swelling / Other: _____

Does it interfere with - Work / Sleep / Daily Routine / Recreation

Activities that make problems worse: Sitting / Standing / Walking / Bending / Lying Down / _____

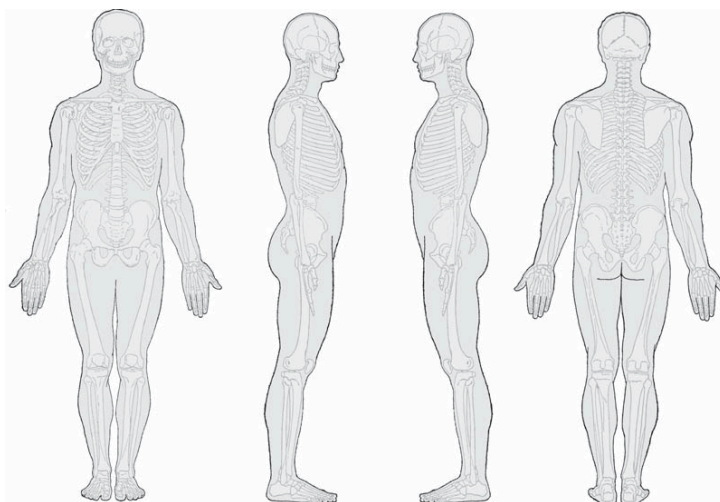
Activities that make problems better: _____

Have you received any other type of treatment for this health concern? Y / N _____

If Yes, was the cause of your health concern identified? Y / N _____

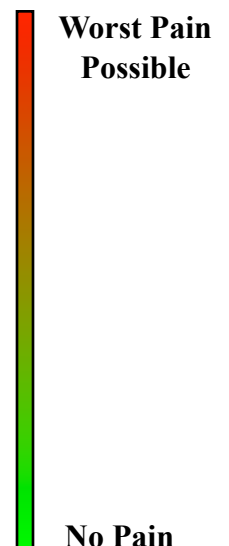
If Yes, what was the recommended course of care? _____

Have you had previous chiropractic wellness care? Y / N Details: _____



Please mark your areas of pain on the diagram on the left.

Please mark a “X” at the level of your pain on the scale to the right.



General History

Given that all prescription medications have side effects, some very serious, please tell us what prescription or over the counter medications you are currently taking and why.

Supplements are becoming more popular these days as people are looking for more natural ways to manage their own health and wellbeing. Please tell us what supplements you are taking and why.

List any traumatic injuries or car accidents:

List all surgeries/hospitalizations and dates:

List any doctors you are currently seeing

Do you have any of the symptoms below today?

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Sunburn | <input type="checkbox"/> Open Cuts, Bruises, Burns |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Irritated Skin Rash |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Cold / Flu | <input type="checkbox"/> Fever |

Slips and falls, although common have a direct impact on your health and wellbeing. Even MINOR falls or accidents can cause long term stress, strain and damage to the spine. In addition to the traumatic injuries listed above, please list any additional slips, falls, etc that you can recall, even if minor.

“The doctor of the future will give no medication, but will interest his patients in the care of the human frame, diet and in the cause and prevention of disease.

- Thomas Edison

Life is not merely to be alive, but to be well.

- Marcus Valerius Martial

Health Concerns Checklist - Please indicate on the list below, "C" for current or "P" for past.

Because the Nervous system controls everything in your body, it is common that current health challenges can be related to the problems you are seeking care for in our office. Please indicate if you currently have or have had any of the following symptoms or health conditions.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fever | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> STD |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Stiffness/Pain | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Numbness in Arms | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Numbness in Hands | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependence | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Numbness in Legs | <input type="checkbox"/> Tumors/Cysts |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cold Hands | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Irritability | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Urinary Tract Inf. |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Vaginal Infection |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Prostate Problem | |

If you have any additional health concerns not listed above, please indicate below:

FAMILY Health History

Please mark below any conditions that apply to your ***FAMILY*** health history.

- | | | |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Circulation Problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Ulcer / Stomach Problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness | |

Lifestyle Questions

It has been shown that daily lifestyle stress significantly impacts your overall health and wellbeing. As a family wellness office we specialize in not only addressing the cause of your health challenges, but we also focus on teaching you how to manage the lifestyle stresses that are keeping you from reaching your optimum health and wellness.

Please rate the following and circle ALL answers that apply to your habits:
(1 being very poor and 10 being excellent)

Eating Habits _____

- A. I eat 3-5x's a day
- B. I eat fruits and vegetables daily
- C. I eat out 2-3 times weekly (min)
- D. I drink 3-5 sodas weekly
- E. I crave sweets
- F. I don't watch what I eat

Exercise Habits _____

- A. I exercise 3-5 times a week
- B. I walk daily
- C. I don't exercise
- D. I want to exercise
- E. I sit (at a computer) 6-8 hours a day

Sleep _____

- A. I sleep 7-9 Hours a night
- B. I wake up well rested
- C. I wake up tired
- D. I toss and turn
- E. I stay up late

Mind Set _____

- A. I have a positive outlook
- B. I am generally in a good mood
- C. I share my feeling easily
- D. I have a negative outlook
- E. I am generally in a bad mood
- F. I bottle things up inside

General Health _____

- A. I am not on medication
- B. I take care of myself
- C. I watch what I eat
- D. I base my health on what everyone around me is doing
- E. I think I am healthy but know I could make some changes to be even healthier

On a scale of 0-10 please describe your levels of stress in the following categories of health:
(0= none / 10=extreme)

Occupational _____ Social _____ Emotional _____ Spiritual _____
Physical _____ Mental _____ Environmental _____

You're Almost There

**Thank you for providing us with the information that can help us to better serve you
and help you to be in the best health you can be!**

Health Goals

At our office we pride ourselves in helping you to achieve phenomenal results with your health and wellness. In order for us to truly help you to be as healthy as possibly, it is important that we understand your goals for your overall health and wellbeing.

Please list your goals for your health and wellness in the spaces provided.

Physical Goals	Nutrition Goal	Stress / Emotional Goals

How can we help you?

It is our goal with every patient that they might live a LONGER, HAPPIER, and HEALTHIER life in some way as a result of the care, education, and inspiration they receive in this office. Though this is our desire, we want to know how you feel. Please answer the following questions.

If we find that there is a need for you to make dietary changes, would you like our recommendations?

_____Yes _____No

If we find that there is a need for you to begin general or specific exercises would you like our recommendations?

_____Yes _____No

If we find there is a need to address emotional or physical stress in your life, would you like our recommendations?

_____Yes _____No

- On a scale of 1-10, with 10 being the highest, how much do you want to get rid of your health problems and move toward wellness, so that you can function better and feel great? _____
- Assuming that we could help you with your conditions or health concerns, is there anything that would prevent you from following through with a treatment plan? _____Yes _____No
- At TLC Chiropractic we are always here to answer any questions you have about your health or your care at our office. If you have any questions or concerns now, please specify below.

Thank you for taking the time to complete all the information necessary to assess you health concerns and goals so we can begin to help you along the path to wellness!

I consent to a complete chiropractic examination and any other diagnostic testing that the doctor deems necessary. I understand the doctor will do their best to explain as much as possible about procedures pertaining to testing and care, and that if I have questions at any time I will ask.

Signature_____

Date_____