

Today's Date: \_\_\_\_\_  
Referred By: \_\_\_\_\_

## *Yorba Linda Wellness Center New Patient Questionnaire*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F

Phone: (H) \_\_\_\_\_ (w) \_\_\_\_\_ (cell) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Pt's SS# \_\_\_\_\_

Marital Status: S M D W / Spouse's Name \_\_\_\_\_

Children  No  Yes ages: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_ Hours worked / week \_\_\_\_\_

### **Health Information:**

What are your objectives in consulting our office? \_\_\_\_\_

What are your health goals once these objectives have been met? \_\_\_\_\_  
\_\_\_\_\_

Do you presently have any health problems, major or minor complaints?  No  Yes ... If yes, explain where and how much:

\_\_\_\_\_  
\_\_\_\_\_

When did this problem start and how long have you had this? \_\_\_\_\_

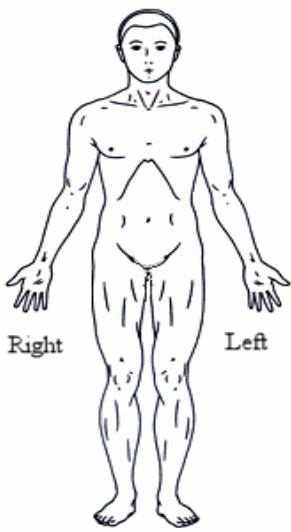
**Current Health**

What are your most pressing health concerns? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

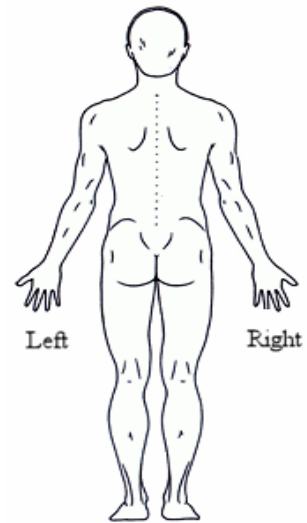
For how long? \_\_\_\_\_

- Is it     getting worse         improving         intermittent  
          constant                     can't say

Where is the problem? Please use the illustrations and lines below to explain



- Front \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
 Back \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



- Do You have:         pain             numbness             tingling             aches  
Is your pain:         sharp             dull             throbbing             constant         intermittent

- Are your symptoms affected by:  
 sitting             standing             walking             bending  
 lying down         weather

Please explain: \_\_\_\_\_

- Do you feel:     cramps             burning             other  
                   swelling             stiffness            \_\_\_\_\_

- Do your symptoms interfere with:  
 work                     sleep                     other  
 day-to-day activities     play                    \_\_\_\_\_

Please explain: \_\_\_\_\_  
\_\_\_\_\_

On a scale of 1-10 (1 least, 10 most), please rate:  
The severity of your symptoms    1   2   3   4   5   6   7   8   9   10

It interferes with (circle all that apply): work family sleep sex sports recreation  
housework happiness ability to relax concentration other \_\_\_\_\_

Have you had previous care for this condition?  No  Yes

Is it getting worse?  No  Yes, How? \_\_\_\_\_

At its worst, how does it feel? \_\_\_\_\_

Do you want to get rid of this condition?  Yes  No

Who was the last doctor who created a health development plan for you if any? \_\_\_\_\_

Did you follow all of the Doctor's recommendations?  Yes  No  I was never put on a health plan

How long were you able to stay on the health development plan? \_\_\_\_\_

What were the results if any? \_\_\_\_\_

What other wellness professionals are currently a part of your health care team?

Massage Therapist  Acupuncturist  Naturopath  Homeopath  Other \_\_\_\_\_

How many Medical Doctor's office visits did you and your family have last year?

None  Less than 5  More than 5  More than 10

Have you had previous Chiropractic Care?  Yes  No This year?  Yes  No

Were you ever put on a Spinal correction program?  Yes  No

If yes, by whom did you complete the program? \_\_\_\_\_

### **Health History:**

Please check all of the following health concerns you have experienced, even if you do not think that your answers relate to your present health concern.

Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory/Vascular Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Digestive Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Heart Condition:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immune System Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Infertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Menstrual Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mood Swings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neck Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Numbness/Tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Urinary Difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vertigo	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Heartburn/Reflux  Yes  No Other: \_\_\_\_\_  Yes  No

List all previous surgeries and dates: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had any broken bones/ fractures? \_\_\_\_\_

List all Medications:  Pain Meds (over the counter/prescription)  Birth Control  Heart Meds  
 Cholesterol Meds  Antidepressant/ Anti-anxiety Meds  Recreational Drugs  
 Anti-Inflammatory Meds  Muscle Relaxers  Aspirin  Other \_\_\_\_\_

If you checked any of the above medications, please list how long you've been on each medication, dosage, and who prescribed them and for what reason are you taking them. It is important to let the doctor know in order to ensure proper interpretation of the diagnostic results with your spinal scans:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any family history of (please circle all that apply):

Cancer Diabetes Heart Disease Arthritis Other \_\_\_\_\_

**Stress History:**

Please indicate whether you have ever experienced stress in any of the following areas. Your answer will enable us to determine which factors have contributed to your present health concerns.

***1) Childhood***

Repeated/Prolonged Antibiotic use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inhaler Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Car Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prescription Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Childhood Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fall/Jump from a height < 3 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaccination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fall/Jump from a height > 3 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Youth Sports	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Traumas (physical or emotional)	

\_\_\_\_\_

***2) Adulthood***

Alcohol Consumption	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inhaler use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Repeated/Prolonged Antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prescription Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Car Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coffee Drinker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Use/Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Sports	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fall/Jump from a height	<input type="checkbox"/> Yes <input type="checkbox"/> No	Extreme Sports	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Workplace Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home Environment Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Traumas (physical or emotional)	

\_\_\_\_\_

**Lifestyle Information**

Do you exercise?  Yes  No  
Do you smoke?  Yes  No

If yes, how much and how often? \_\_\_\_\_  
If yes, how much? \_\_\_\_\_

Do you consume alcohol?  Yes  No If yes, how much and how often? \_\_\_\_\_  
Do you drink soft drinks (diet or regular)?  Yes  No If yes, how often? \_\_\_\_\_  
Do you drink water?  Yes  No If yes, how much and how often? \_\_\_\_\_  
Do you drink coffee?  Yes  No If yes, how much per day? \_\_\_\_\_  
Do you rate your nutritional habits?  Great  Good  Fair  Poor  
Do you take any vitamins/supplements?  Yes  No If yes, what kind? \_\_\_\_\_

Lifestyle information cont':

How many hours of sleep do you usually get? \_\_\_\_\_  
Is it the quality of sleep:  Great  Good  Fair  Poor

Stress level (personal):  Low  Medium  High  
Stress level (at work):  Low  Medium  High

What do you do to relieve or handle your stress? \_\_\_\_\_

Which best describes your reason for consulting the office?

- I have a specific concern and require help only with this
- I want to ensure that my health concerns do not become an ongoing problem that will impact my future health
- I want to be healthier five years from now than I am today

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Would you like for us to verify your insurance eligibility?  Yes  No If yes, what is the name of your Insurance company? \_\_\_\_\_

Group #: \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Assignment and Release**

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_  
And assign directly to Dr. Kevin Shaevitz, DC all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chares whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature Date Relationship to Patient

\_\_\_\_\_  
Patient Signature (all information is filled out accurately to the best of my knowledge) Date