COMPREHENSIVE *Wellness Center*

555 S. Rancho Santa Fe Rd. Ste 200 San Marcos, CA 92078 (760) 736-0286 cwcsanmarcos@gmail.com

PERSONAL INFORMATION

Date:__________________ First Name: _________________________ Last Name:_________________________

Home Phone ______________________ Work Phone:______________________ Cell phone: _________________

Contact Preference: ❒Call ❒Text ❒E-mail E-mail:____

Address: ____ Apt #: __________ Ste: __________

City: _____________________ State:________ Zip:___________ License #: ___________________

DOB (MM/DD/YYYY): _____________ Age:______ Height:_______ Weight: _____lb Sex: ❒M ❒F

Are you pregnant?: ❒Yes ❒No If so, how many weeks?: _______

What is your current status?: ❒Minor ❒Single ❒Married ❒Divorced ❒Separated ❒Other: ___________

Referred by: ______________________________ Social Security #: ____________________________

OCUPATIONAL DATA

Business/Employer:_____________________ Work Title:__________________ Phone: ____________________

Address: _________________________________ City: _________________ State: ________ Zip: ________

EMERGENCY CONTACT

Name:_____________________________ Relationship: __________________ Phone: _____________________

Address: ____ City: _______________ State: _______ Zip: ________

I _______________________ authorize this contact to have access to my medial records and to speak and take action on my behalf when necessary.

PATIENT COMPLAINT

Main Complaint: ________________________ Draw (**X**)

2nd Complaint: ________________________ Draw (**S**)

3rd Complaint: ________________________ Draw (**T**)

Draw an (S) on areas of your 2nd complaint, and a (T) for the 3rd

1. When did your symptoms start? ___________________________
2. Is your condition getting progressively worse? ❒Yes ❒No
3. Describe your pain:
   ❒Dull ❒Sharp ❒Stiff ❒Tingling
   ❒Stabbing ❒Burning ❒Numb ❒Achy
4. What do you rate your pain on a scale of 1 -10 (low to high)
   1 2 3 4 5 6 7 8 9 10
5. What makes your condition worse? (e.g. Bending, Sitting too long)
   ____
6. What makes your condition better? (e.g. Ice, Heat, Stretching)
   ____
7. Who have you revived treatment by regarding this condition:
   ❒Primary Care Physician ❒PT ❒Massage ❒Acupuncture
   ❒Chiropractor ❒None ❒Other ____________________

Draw an (**X**) on the affected areas above to indicate the location of your pain and a (**O**) for numbness.

Health History

Name: ______________________ Date ____________

Please answer the following questions to help us determine possible risk factors:

1. Have you ever become dizzy or lost consciousness when turning your head? ❐ Yes ❐ No
2. Do you have any metal implants? ❐ Yes ❐ No
3. Are you currently on any medications? ❐ Yes ❐ No If so please list them: ____________________
4. Have you had any spinal or brain surgery? ❐ Yes ❐ No
5. Have you had any of the following problems?
   - Sudden weakness in the arms or legs? ❐ Yes ❐ No
   - Numbness in the genital area? ❐ Yes ❐ No
   - Recent inability to urinate or lack of control when urinating? ❐ Yes ❐ No
6. Please draw an (**X**) to the **left** of the condition if **you** have ever been diagnosed with any of the following diseases or disorders. Please draw an (**X**) to the **right** of the condition if it relates to a **direct family member**, and state the relationship to you on the **right**.

❑	Osteoarthritis	❑	________	❑	Diabetes	❑	________	❑	Spinal Stenosis	❑	________
❑	Osteoporosis	❑	________	❑	Concussion	❑	________	❑	Rheumatoid Arthritis	❑	________
❑	Heart Disease	❑	________	❑	Migraine	❑	________	❑	Asthma	❑	________
❑	Cancer	❑	________	❑	Hepatitis	❑	________	❑	Hernia	❑	________
❑	Tuberculosis	❑	________	❑	STD	❑	________	❑	Other________		
❑	Ankylosing Spondylitis	❑	________	❑	High Blood Pressure	❑	________	❑	Other________		

Past Health History:

1. Have you had any major surgeries? ❐ Yes ❐ No If so please list them: ____________________
2. Have you had any bone fractues? ❐ Yes ❐ No If so please list them: ____________________
3. Have you ever been hospitalized? ❐ Yes ❐ No If so please list them: ____________________
4. Have you ever been involved in a car accident(s)? ❐ Yes ❐ No
   If so please list the them: ____________________
5. Have you had any major falls? ❐ Yes ❐ No If so please list them: ____________________
6. Have you had any joint dislocations? ❐ Yes ❐ No If so please list them: ____________________
7. Have you had any imaging done such as MRI(s) or X-rays? ❐ Yes ❐ No
   If so please list the body parts and dates: ____________________

Health Questionnaire

Name:_________________________ Date_______________

1. How often do you exercise? ❑ None ❑ Lightly ❑ Moderately ❑ Heavily

2. What is the nature of your work activity? ❑ Sitting ❑ Standing ❑ Light Manual Labor ❑ Heavy Manual Labor ❑ Computer Work

3. How long do you sleep for (hours)? __________ Is it restful sleep? ❑ Yes ❑ No

4. What position do you sleep in? ❑ Back ❑ Stomach ❑ Right Side ❑ Left Side ❑ Various

5. Do you smoke tobacco products or electronic cigarettes (vape)? ❑ Yes ❑ No

6. Do you consume alcohol? ❑ Yes ❑ No If yes, how often: _______________________________

Comprehensive Wellness Center Agreement

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.
I understand that providing incorrect information can be dangerous to my health.
I agree to notify this doctor immediately whenever I have changes in my health condition(s) in the future.
I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.
Should I be unable to meet the terms of this agreement at any time, I agree to notify the office immediately.

_______________________________ _______________

Patient Signature Date

_______________________________ _______________

Parent or Guardian Signature (if patient is minor) Date