

# Julia Lewis, D.C.

Wellness Solutions/Non-Force Chiropractic Center  
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## PATIENT INFORMATION SHEET

eMail: \_\_\_\_\_

Date \_\_\_\_\_ Number (to confirm appointment) \_\_\_\_\_

Name \_\_\_\_\_ Phone (Home) \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Marital Status S M D W

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Telephone (Work) \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Telephone (Work) \_\_\_\_\_

Referred By \_\_\_\_\_ Past Chiropractic Care  Yes  No When \_\_\_\_\_

Previous Chiropractor's Name \_\_\_\_\_ Results \_\_\_\_\_

Areas where you hurt

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Are your present complaints due to an injury?  No  Yes  On the job  Auto Accident  Other \_\_\_\_\_

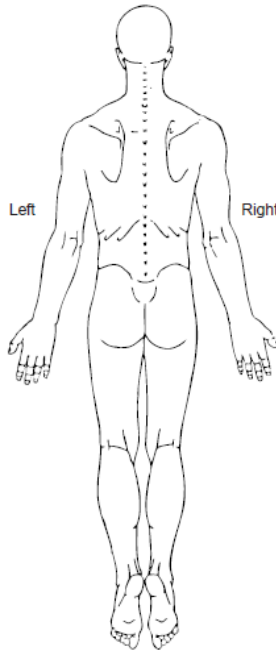
Have you made a report of your accident?  No  Yes  To employer  Auto Carrier  Other \_\_\_\_\_

Are you now or have you ever been disabled? (Service or Work)?  No  Yes  When \_\_\_\_\_

Have you retained an attorney?  No  Yes Name & Telephone \_\_\_\_\_

To help us better explain your chiropractic condition and how we may be able to help you, please check the best answer:

1. I remember important things in my life by
  - what I see.
  - what I hear.
  - what I feel.
2. The primary reason I brush my teeth is to
  - avoid tooth decay and gum disease.
  - make sure I have healthy teeth and gums.
3. When I make decisions I generally
  - gather facts and weigh the evidence.
  - make the right choice instantly.
  - consult my friends and family.
  - depend upon how I "feel" about it.



**Severity of Pain**  
List region of pain and circle severity number. [ 1= least, 10 greatest ]

example: Neck  
1 2 3 (4) 5 6 7 8 9 10

Circle on Diagram  
Where you hurt

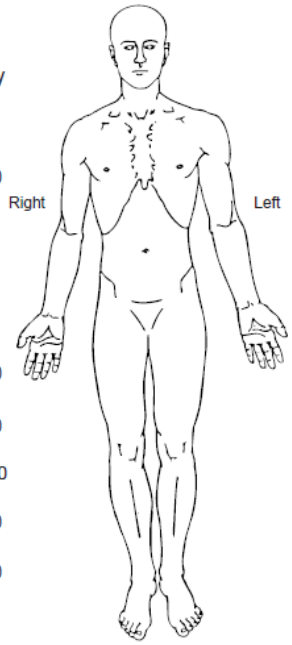
1 \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

2 \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

3 \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

4 \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

5 \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10



**HABITS**

Smoking Packs / day \_\_\_\_\_

Drinking Alcohol \_\_\_\_\_

Coffee Cups / Day \_\_\_\_\_

**EXERCISE**

None

Moderate

Daily

**FAMILY HISTORY**

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother No. of ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister No. of ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## OPERATIONS AND MEDICAL PROCEDURES

DATE \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please enter : "P" (Previously), "C" (Currently), In front of any of the following historically significant symptoms. Leave blank if never or only rarely experienced.

GENERAL SYMPTOMS	GASTRO-INTESTINAL	RESPIRATORY	GENITO-URINARY
<input type="checkbox"/> Headache	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Fever	<input type="checkbox"/> Poor Digestion	<input type="checkbox"/> Spitting Blood	<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Chills	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Spitting Phlegm	<input type="checkbox"/> Blood In Urine
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Belching or Gas	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Fainting	<input type="checkbox"/> Nausea	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Inability to control Urine
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Asthma	<input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Pain over Stomach		
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Constipation		
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Diarrhea		
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Colon Trouble		
<input type="checkbox"/> Numbness in (Circle) arms/legs/hands/feet	<input type="checkbox"/> Hemorrhoids		
<input type="checkbox"/> Pain in (Circle) arms/legs/hands/feet	<input type="checkbox"/> Liver Trouble		
	<input type="checkbox"/> Jaundice		
	<input type="checkbox"/> Gall Bladder Trouble		

MUSCLE & JOINTS	CARDIO VASCULAR	SKIN OR ALLERGIES	FOR WOMEN ONLY
<input type="checkbox"/> Weakness	<input type="checkbox"/> Rapid Heart	<input type="checkbox"/> Skin Eruptions	<input type="checkbox"/> Painful Periods
<input type="checkbox"/> Twitching	<input type="checkbox"/> Slow Heart	<input type="checkbox"/> Itching	<input type="checkbox"/> Excessive Flow
<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bruising Easily	<input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> Backache	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Dryness	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Pain over Heart	<input type="checkbox"/> Boils	<input type="checkbox"/> Cramps or Backaches
<input type="checkbox"/> Tremors	<input type="checkbox"/> Previous Heart Trouble	<input type="checkbox"/> Sensitive Skin	<input type="checkbox"/> Miscarriage
<input type="checkbox"/> Foot Trouble	<input type="checkbox"/> Swelling Ankles	<input type="checkbox"/> Hives	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Painful Tail Bone	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Eczema	<input type="checkbox"/> Pregnant at this Time
<input type="checkbox"/> Pain Between Shoulders	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Allergy	<input type="checkbox"/> Last Pap
<input type="checkbox"/> Hernia	<input type="checkbox"/> Strokes		By Who _____
<input type="checkbox"/> Spinal Curvature			Other _____

List any accidents or falls and dates:  Car \_\_\_\_\_  Recreational Vehicle \_\_\_\_\_  Sports \_\_\_\_\_  
 School \_\_\_\_\_  Other \_\_\_\_\_

List any broken bones or dislocations (Fractures): \_\_\_\_\_

Ever on crutches?  No  Yes Why? \_\_\_\_\_

Have you ever had any spinal taps or spinal injections?  Yes  No

Were you ever knocked unconscious?:  Yes  No Have you ever had a lapse of memory?:  Yes  No

Have you ever had x-rays taken?:  No  Yes \_\_\_\_\_ When? \_\_\_\_\_ By whom? \_\_\_\_\_

For what ailments were these pictures made? \_\_\_\_\_

Do you suffer from any condition other than that for which you are now consulting us? \_\_\_\_\_

Are you presently taking any medication - prescription or over the counter?  No  Yes

What Drugs? \_\_\_\_\_

I understand that the payment for the care provided in this office is due at the time of service. I will be provided with a receipt for payment of services which I may send to my insurance company for appropriate reimbursement.

A missed appointment is a disappointment. If for any reason an appointment cannot be kept, I promise to notify at least 24 hours in advance to avoid full appointment charge.

Patient Signature/Guardian Authorizing Care

Date

I am covered by Medicare or Advantra Freedom (please circle which one and initial)

Please give me a receipt for my insurance, Medical Savings or Flex Spending Account Yes or No (circle)