



CONFIDENTIAL PATIENT DATA

If you need assistance completing this form, please ask the receptionist

PATIENT INFORMATION

Name: _____
 Address: _____
 City: _____
 Home Phone: (____) _____ - _____
 Date of Birth: _____
 Social Security Number: _____
 Occupation: _____
 Work Phone: (____) _____ - _____
 Marital Status: Single Married
 Name of Spouse or Nearest Relative: _____

TODAYS DATE: _____
 Male Female
 State: _____ Zip: _____
 E-mail Address: _____
 Cell Phone: _____
 Age: _____ Height: _____ Weight: _____
 Employer: _____
 Other _____
 Phone of Relative: (____) _____ - _____

Who can we thank for referring you to our office? _____
 If you were not directly referred to our office, how did you find us? _____
 Advertisement: _____
 Convenient Location Yellow Pages
 Attended Seminar: _____
 Dinner Talk: _____
 Web Search – keywords: _____
 Other _____

MEDICAL HISTORY

SURGICAL HISTORY:

1. _____
2. _____
3. _____

AGE: _____ DATE: _____
 AGE: _____ DATE: _____
 AGE: _____ DATE: _____

ACCIDENT HISTORY:

1. _____
2. _____
3. _____

AGE: _____ DATE: _____
 AGE: _____ DATE: _____
 AGE: _____ DATE: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS

Please rate the symptoms from 1-10 with 1 as mild and 10 as severe

with #1 as the primary reason you are seeking care

1. _____
2. _____
3. _____

Symptoms began on the day of: _____

Symptoms developed from: _____

- Job Related Auto Injury Other Accident Illness Gradual Onset Unknown Cause

Date of last physical exam: _____

Have you been treated by a physician for this or any other health condition in the last year? Yes No

Describe Condition: _____

Name(s) and location(s) of Doctor(s) previously seen for present condition(s): _____

Are you taking any prescription medications? Yes No Please describe the condition that the medication is for:

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Are you taking any over-the-counter medications? Yes No Please describe the condition that the medication is for:

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Please Mark ALL PAST AND PRESENT Conditions:

Would You Like This Condition Treated at Gault Wellness Center?

| | Past | Present | No | Yes – ASAP | Maybe in the Future |
|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Acid Reflux / Indigestion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies / Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety / Panic Attacks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder / Kidney Trouble | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bowel Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Catch Colds / Flu Easily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic Fatigue / Tire Easily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Confusion / Loss of Concentration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression / Weeping Spells | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes / Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness / Loss of Balance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever / Chills / Sweats | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches / Migraines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Head Seems Heavy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure / Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Immune System Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Irritable Bowel / I.B.S. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lyme Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Multiple Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscular Dystrophy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nausea / Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervousness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness / Tingling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatoid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ringing / Buzzing in Ears | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory / Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep Problems / Insomnia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stress / Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Problems / Ulcer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision Blurred / Sensitive to Light | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please Check All That Apply PAST & PRESENT:

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Seizures / Convulsions | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Radiation | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> AIDS / <input type="checkbox"/> HIV | <input type="checkbox"/> Venereal Disease |
| Have you ever had a metal implant? <input type="checkbox"/> Yes / <input type="checkbox"/> No | | | | |
| Have you ever had a gunshot wound? <input type="checkbox"/> Yes / <input type="checkbox"/> No | | | | |

| | | |
|-------------------------------|--|----------------------------|
| <u>For Women Only:</u> | Are You Pregnant? Yes / No / I'm not sure | Date of last period: _____ |
| PMS Yes / No | Menstrual Cramps Yes / No | Miscarriage(s) Yes / No |

Patient Signature: _____

Date: _____