# Core Wellness Center

## Personal Information

**Referred By:**___________________________

Last Name:______________________ First Name:___________________ DoB:___________

Address:________________________________ City:___________________ State:_______ Zip:_________

Phone:____________________________ Email:__________________________________ Age:_____ Sex: _____

Occupation:____________________ Marital Status: Single/Mar/Div/Widow # of Children:_____ Ages:_________

### Emergency Contact

Name/ Phone:_____________________________________________________ Relation:______________________

## Reason for Visit

________________________________________________________________________________________________

### Medical Care Information

Do you have a family Doctor? N / Y Name of Doctor: _____________________________________________________

Do you have a family Chiropractor? N / Y Name of Chiropractor:____________________________________________

Have you had any surgeries in the last 5 years? N / Y Date of last surgery:______________

## Present Illness / Conditions (Circle all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Allergies | Cancer | Epilepsy | HIV-AIDS | Prostate Issues | Thyroid Issues |
| Anemia | Cirrhosis/Hepatitis | Hay Fever | Kidney Problems | Rheumatic Fever | Tuberculosis |
| Arthritis | Diabetes | Heart Problems | Mental/ Emotional Difficulty | Scoliosis | Ulcers |
| Asthma | Dislocated Joints | High Blood Pressure | MS | Sinus Issues | Polio |
| Bone Fractures | Diverticulitis | Low Blood Pressure | Pacemaker | Spinal Disc Disease | STD's |

Other:__________________________ Date Diagnosed/Treatment Plan________________________________

## Family History of Illness (Circle all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Allergies | Cancer | Epilepsy | Kidney Problems | Rheumatic Fever | Tuberculosis |
| Anemia | Cirrhosis/Hepatitis | Heart Problems | Mental/ Emotional Difficulty | Scoliosis | Ulcers |
| Arthritis | Diabetes | High Blood Pressure | MS | Sinus Issues | Polio |
| Asthma | Dislocated Joints | Low Blood Pressure | Pacemaker | Spinal Disc Disease | |
| Bone Fractures | Diverticulitis | HIV-AIDS | Prostate Issues | Thyroid Issues | |

Other:__________________________________________________________________________________

## Social History

| | | | |
|---|---|---|---|
| Alcohol? N / Y<br>Drinks Per Week? | Cigarettes? N / Y<br>Packs per Day? | Caffeine? N /Y<br>Drinks per Day? | Exercise? N / Y Light/Mod/Adv<br>Hours per Week? |

Signature:___________________________________ Date:_________________

All questions contained in this questionnaire are confidential and will become part of your medical record