Auth Chiropractic & Vitality: Chelation, Ozone & Infusion Center

New Patient Paperwork

DEMOGRAPHICS

Today's Date: ___/___/_____ First Name: _____ Middle Initial: ___ Last Name: _____

Date of Birth: ___/___/_____ Physical Address: _____State:_____ Zip code:_____

Mailing Address: _____ State:_____ Zip code:_____Sex:_____M_____F_____or_____

Physical Address: _____State: _____Zip Code:_____SS#: _____-_____-_____

Phone number #1 (best # to reach me): (_____)_____-_____ Phone number #2: (_____)_____-_____

Email address: _____@_____.com Occupation: _____

Employer:_____ Relationship status: (Single, Married, Divorced, Widowed, other):_____

Emergency Contact: Name: _____Relationship: _____ Phone number:(_____)_____-_____

How did you hear about us:_____Who is your primary care provider:_____

MEDICAL HISTORY

Height:_____Weight:_____ Reason for your visit:_____

What symptoms are you having that brought you in today:_____

How long have you been having them:_____ What is your diagnosis (if any):_____

What else have you tried as treatments:_____

Response to other treatments:_____

What other healthcare providers have you seen for this: _____

Have you been hospitalized for these symptoms/diagnosis(es):_____

Are your symptoms (circle): Getting worse Staying the same Improving Other:_____

Other treatments you are interested in/wanting to explore:_____

Have you ever worked/lived in a situation where you were exposed to metal/metal components: (Circle): YES NO

If yes, explain:_____

Have you ever worked/lived in a situation where you were exposed to chemicals: (Asbestos, pesticides, herbicides, gasoline, oil, diesel, solvents, other)- (Circle): YES NO If yes, explain:_____

Do you live/have lived very close to power lines: (Circle): YES NO If yes, explain:_____

What type of water do you drink: (Circle) Tap Filtered tap Reverse osmosis Vaporized Distilled Other:_____

Concerned about current/past mold exposure: (Circle): YES NO If yes, explain:_____

Have you ever been tested for heavy metals: (Circle): YES NO If yes, explain:_____

Have you ever been treated for heavy metal poisoning or overload: (Circle): YES NO If yes, explain:_____

Are you vaccinated to COVID: (Circle): YES NO If yes, how many doses: _____ Last dose: _____

Were you vaccinated as a child: (Circle): YES NO Have you ever had a vaccine reaction: (Circle): YES NO If yes, explain:_____

Medical conditions (present & past diagnoses): _____

_____

Surgeries: _____

Current medications: Drug name, dose, frequency, started:

_____

_____

_____

Current supplements/vitamins/minerals/herbs: Drug name, dose, frequency, started:

_____

_____

_____

List past medications (no longer taking): _____

_____

Allergies (to medications or other): Circle: No known Allergies or Allergies & reaction:_____

_____

Do you have/had a diagnosis of cancer: Circle: YES NO If yes, explain:_____

Family History:

Relation	Living/Deceased (L / D)	Health conditions
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Siblings:		
Children:		

***Females:** Last menstrual period: ___/___/_____

Total # pregnancies:____# of children:____# Miscarriages:____# Elective Abortions:____Age of children:_____

Lifestyle:

Diet:_____ Caffeine: (cups per day) (coffee, soda, energy drinks, other):_____

Daily water intake (approximately ounces):_____ Would you say you drink enough water every day: Circle: YES NO

Do you exercise: Circle: YES NO If yes, what type/how often:_____

Do you smoke: Circle: YES NO If yes, how much, how often, for how long:_____

Have you ever smoked: Circle: YES NO If former smoker: how long did you smoke for: _____

How much did you smoke:_____ When did you quit: _____

Do you use other nicotine products: Circle: YES NO If yes, what type, how long, how often:_____

If yes to the use of nicotine products, are you interested in quitting: Circle: YES NO Ready to quit 0-10: _____

How many alcoholic beverages do you drink per week:_____ Per month:_____How often >6 in a day:_____

If you do not drink, did you quit due to problems with drinking: Circle: YES NO History of treatment: Circle: YES NO

Do you use THC/ marijuana: Circle: YES NO If yes, how much do you use: _____ Medical or recreational (Circle)

Do you use other recreational drugs: Circle: YES NO If yes, what type/s, how much, how often, and for how long have you been using them:_____

SYMPTOMS:

In addition to any symptoms, you already listed above, please **CIRCLE** any of the following additional symptoms you are having:

Constitutional:	Neuralgia (nerve pain)	Pain with breathing	Low blood pressure	Dark urine
Chronic fatigue	Fainting/Passing out	**Ear, Nose, Throat:**	High blood pressure	Not enough urine
Frequently sick	Concentration trouble	Sinus infections	Easy bleeding	**Skin:**
Chills	Seizures	Nasal congestion	**Gastrointestinal:**	Rashes
Myalgias	**Mental Health:**	Lymph nodes swollen	Abdominal pain	Excessive dry skin
Fevers	Depression	Trouble smelling	Nausea/vomiting	Pale skin (change)
Weight loss/gain	Anxiety	Hearing loss	Diarrhea	Easy bruising
Feeling cold/hot	Insomnia	Pulsation in ears	Constipation	Itching
Excess sweating	Mood swings	Tinnitus (ringing ears)	Heart burn	Chronic wounds
High/Low Glucose	Irritability	Vision problems	Blood vomit/stool	**Musculoskeletal:**
Neurological:	Suicidal thought/action	Mouth sores	Blood/dark/gray stool	Muscle pain/stiffness
Memory loss	Eating Disorder	Bleeding gums	Excess gas/belching	Joint pain/stiffness
Tremors	Relationship stress	Trouble with taste	Incontinence stool	Joint redness/swelling
Confusion	Excess life stressors	Taste metal in mouth	Trouble swallowing	Muscle twitching
Brain fog	Grieving	**Cardiac:**	**Urinary:**	Back or Neck pain
Balance trouble	**Respiratory:**	Chest pains	Burning with urinating	**Females:**
Coordination trouble	Shortness of breath	Palpitations	Urgency/frequency	Hot flashes
Dizziness	Wheezing	Fast/Slow heartbeat	Blood in urine	Menstrual trouble
Weakness	Snoring	Leg swelling	Incontinence urine	**Males:**
Neuropathy	Waking gasping	Pain in legs w/ walk	Frequent UTI's	Penile/testicle trouble

Signature of patient:_____ Date: _____

Name of Provider: _____

Signature of Provider: _____ Date: _____