EnVitality Wellness Center, LLC
Dr. Jacqueline L. Berens, DC
www.EnVitalityWellness.com

PLEASE NOTE:
This file must be saved to your desktop before and after completing!
Email completed PDF to ***englewood@twwclinics.com***

Personal Information

Date: ________________ **How were you referred to the office?** ____

Name: ____

Date of birth: ____________ **Age:** _____

Address: ____ **City:** ____________________ **State:** ______**Zip:**__________

Home Phone: (____)____________ **Cell Phone:** (____)____________ **Work Phone :** (____)_____________

E-mail: ____

Would you like join our email list to receive monthly health tips, office updates, and more? ☐ **Yes** ☐ **No**

Please note that your email will be exclusively used by EnVitality Wellness Center, LLC and will not be disclosed to any third parties.

Marital status: ☐Single ☐Married ☐Widowed ☐Divorced **Spouse/Partner:**____________________________

Occupation: _____________________________ **Employer:** ____

Names & Ages of Children (Optional):

____

Family Medical Doctor: ____ **Office Phone**:(____)________________

Date of last physical exam:_________________

May we update your family doctor regarding your care at this office if needed? ☐ **Yes** ☐ **No**

Health History

What is your EnVitality Rating? *(How healthy do you feel when compared to others)*
Please circle: 0 Not Very Healthy, 10 Very Healthy
0 1 2 3 4 5 6 7 8 9 10

What brings you to the office today?

____
____
____
____
____
____

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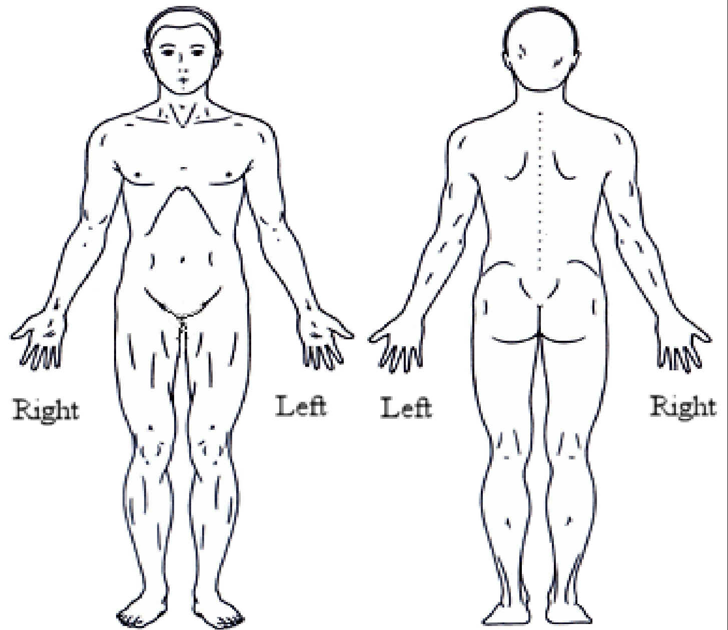
Circle the area(s) you are experiencing a difficulty:



Please mark the area(s) of concern below:

Please circle degree of pain: 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10

Use the symbols below to mark specific types of pain you are experiencing on the picture to the right:

Numbness	= = =	Dull Ache	OOO
Burning	XXX	Sharp/Stabbing	/ / /
Pins, Needles	+ + +	Other	^ ^ ^

Date symptoms appeared/accident happened: ____

What activities aggravate your condition/pain? ____

What activities lessen your condition/pain? ____

Is this condition worse during certain times of the day? ☐ Yes ☐ No **Time(s):**______________________

Is this condition interfering with work? ☐ Yes ☐ No **Sleep?** ☐ Yes ☐ No **Daily Routine?** ☐ Yes ☐ No

Is this condition progressively getting worse? ____

Is this due to: ☐ **Auto** ☐ **Work** ☐ **Other** **If other please describe:** ______________________

Have you had the same or similar condition before? ☐ Yes ☐ No **If yes, when and describe**:________________

____

Social History

Do you drink alcohol? ☐ Yes ☐ No **If yes, how many drinks per week:** _______

Do you use tobacco products? ☐ Yes ☐ No **Do you smoke?** ☐ Yes ☐ No **If yes, how many packs per day:** ____

Do you consume caffeine? ☐ Yes ☐ No **If yes, how many drinks per day and what type:** ____________________

Do you exercise? ☐ Yes ☐ No **If yes, what kind(s):** __________________________ **& How often:** _____ per wk

How many hours per night of sleep do you get on average? _____ hours/night

Do you wake up during the night? ☐ Yes ☐ No **If so, how often:** ______ per night

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Health and Wellness History

To help our office understand your wellness goals and give you the type of care that you want, please use this chart to answer the questions below.

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
I have serious concerns about my overall health	I feel worried about my health	I have constant concerns that affect my health	I have health challenges that affect me on a daily basis	I have some minor complaints about my health	I feel okay about my health with no complaints	I feel good most days	I feel well on a daily basis	I feel energetic and healthy	I feel active, energetic and fit	I feel great and am proactive about my health

What number best describes how you feel about your health today? ______

Where would you like your health to be? ______

How many servings of fruit do you consume per day? _______

How many servings of vegetables do you consume per day? _______

How many servings of protein do you consume per day? _______

How many servings of bread/crackers/pasta do you consume daily? _______

Do you consume artificial sweeteners? ☐ Yes ☐ No **If yes, what brands?** ________________________________

Do you consume fast food? ☐ Yes ☐ No **If yes, what do you typically eat?** ________________________________

Do you eat breakfast? ☐ Yes ☐ No **If no, what time is your first meal of the day?** ________________________

Are you currently taking any medications? ☐ Yes ☐ No **If yes, please list:** ______________________________

____

Are you currently taking any supplements? ☐ Yes ☐ No **If yes, please list:** ______________________________

____

Please indicate the areas of health that you want to improve:

____ Lose weight **___ More energy** **___ Sleep better** **___ Improve digestion**

____ Improve blood work **___ Prevent problems** **___ Anti-aging support** **___ Improve general health**

If you could improve ONE thing about your health, what is your priority? __________________________________

____

Would you be interested in a complete nutrition evaluation? ☐ Yes ☐ No

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Medical History

Please mark each item below if you Currently have or Previously had with a C or P:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness/Anxiety
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain Between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Foot/Feet Problems
__ Arch/Heel Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Sprains/Strains
__ Broken Bones
__ Arthritis

CARDIO-VASCULAR
__ High Blood Pressure
__ High Cholesterol
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Stroke
__ Swelling Ankles
__ Varicose Veins

IMMUNE
__ Lupus
__ Multiple Sclerosis
__ Fibromyalgia
__ Rheumatoid Arthritis

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

METABOLIC
__ Hyperthyroid
__ Hypothyroid
__ Grave's Disease
__ Hashimoto's Disease

SURGERY
☐ Yes ☐ No
If yes, describe:______________

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy:__________________

CANCER
☐ Yes ☐ No
If yes, what type:______________

FOR WOMEN ONLY:
__ Birth Control:______________
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
__ Miscarriage
__ Fertility Problems

Pregnant at this Time: ☐ Yes ☐ No
If yes, how many weeks:___________

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Consent For Care

TERMS OF ACCEPTANCE: I, the patient, have been advised about chiropractic care, and like all types of health care, chiropractic can hold certain risks. While the risk are most often very minimal, in rare isolated cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. I, the patient, have been advised about deep tissue laser therapy, and like all types of health care, therapy lasers can hold certain risks. The primary safety precaution when using therapy lasers is eye protection. Lasers can pose optical risks if the eye is exposed to the laser light. The therapeutic dose of laser light not in the visible light spectrum and therefore is not visible to your eye. Laser-safe eye protection is provided and must be worn by all individuals within the treatment area to ensure a safe environment.

When a patient seeks chiropractic health care, deep tissue laser therapy, and/or any other service provided in our office and we accept a patient for such care, it is absolutely essential for both Patient and Doctor to be working towards the same health objective. Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at the EnVitality Wellness Center, LLC, have been explained to me to my satisfaction, all my questions have been answered, and I have conveyed my understanding to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care, and agree to hold them harmless of consequences thereof.

AUTHORIZATION AND RELEASE: I, the patient, understand and agree to allow EnVitality Wellness Center, LLC, to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. I understand and agree that I am responsible for all costs of care at the time of service, unless otherwise arranged. My Patient Health Information and my rights concerning these records will be protected according to HIPAA.

FEMALES ONLY REGARDING X-RAY/IMAGING STUDIES:
Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ______/______/______ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination if the doctor has deemed it necessary in my case.

Patient's Signature: ____ Date: _________________

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OFFICE USE ONLY

Dr. Notes:____

____

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Doctor's Signature: ______________________________________ **Date:** ____________________

Dr. Jacqueline L. Berens, DC