Tree of Life Health and Wellness
315 North Aurora Street
Ithaca, New York 14850

NEW PATIENT INFORMATION

Full Name:_____Gender: _____

Age:_____ Birth date:_____ E-mail:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: (_____)_____Cell Phone: (_____)_____

Marital Status: S M D W # of Children:_____ Work Status: Full time Part time Retired Student Pregnant? Y N

Employer:_____ Occupation(s):_____

Employer Address:_____ Work Phone: (_____)_____

Name of Spouse/Partner, Parent/Guardian:_____ Spouse/Partner's Occupation:_____

In case of emergency contact: _____ Relationship:_____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Medical Doctor:_____ Date of Last Visit:_____ Reason:_____

Previous Chiropractor: _____ Date of Last Visit:_____ Reason:_____

How did you hear about our clinic? Whom may we thank for referring you? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of you PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1) The patient understands and agrees to allow Tree of Life Health & Wellness to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2) The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3) A patient's written concern need only be obtained one time for all subsequent care given to the patient in this office.
4) The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5) For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Tree of Life Health & Wellness to assure that your records are not readily available to those who do not need them.
6) Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7) If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the doctor of chiropractic/healthcare provider has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.

Signature _____ **Date**_____

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HEALTH CONCERNS: Please list your top health concerns in order of priority.

1._____

2._____

3._____

4._____

TREATMENT: What type of health care are you looking for?

I am looking for the most minimal amount of care to "patch up the symptoms" of my problem
I am looking to resolve my symptoms and then go on to "fix the cause" of my problem
I am looking to take care of my problem and then go on to "achieve optimal health and wellness"

COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first notice the problem?_____ Was there anything that brought it on?_____

When did you first seek treatment for this problem?_____ Has another doctor(s) treated you for this condition? **Y N**

If yes, whom?_____ Treatment(s):_____

Have you had any intolerance or reactions to treatments? **Y N** Describe:_____

If this is a reoccurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____ Has it become worse recently? **Y N** Same Better Gradually worse

How frequent is the condition? Constant Daily Intermittent Night only How long does it last? All day Few hours Minutes

Is this condition interfering with your: Work Sleep Daily routine Recreation Other:_____

How long has it been since you felt good? Days Weeks Months Years >10years

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other:_____

What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other:_____

Time of day when pain is worst: __Morning __Afternoon __Evening __Wakes Me Does the pain radiate? _____

Is there anything that you can do to relieve the problem? Y N If yes, describe: _____

If no, what have you tried to do that has not helped? _____

What do you believe is wrong with you? _____

Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? _____

Have you been in an auto accident? Past year Past 5 years Over 5 years Never

Describe: _____

In relation to your other health concerns: _____

2-When did you first notice the problem?_____ Was there anything that brought it on?_____

How did it originally occur? _____ Has it become worse recently? **Y N** Same Better Gradually worse

How frequent is the condition? Constant Daily Intermittent Night only How long does it last? All day / Few hours / Minutes

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other:_____

3-When did you first notice the problem?_____ Was there anything that brought it on?_____

How did it originally occur? _____ Has it become worse recently? **Y N** Same Better Gradually worse

How frequent is the condition? Constant Daily Intermittent Night only How long does it last? All day Few hours Minutes

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other:_____

4-When did you first notice the problem?_____ Was there anything that brought it on?_____

How did it originally occur? _____ Has it become worse recently? **Y N** Same Better Gradually worse

How frequent is the condition? Constant Daily Intermittent Night only How long does it last? All day Few hours Minute.

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other:_____

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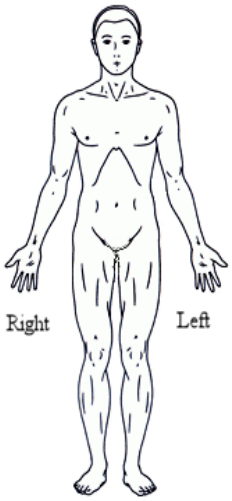
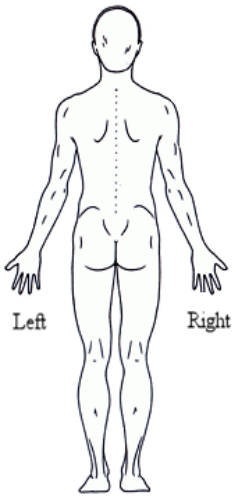
Pain Chart

Please circle on the pain scale from 0 to 10 the pain you feel with this condition,
10 being the worst pain you have felt with this condition, 0 being no pain.
Mark areas of pain on figures below.





Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Shoulder, Arm Pain
0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back Pain
0 1 2 3 4 5 6 7 8 9 10

Hip, Leg Pain
0 1 2 3 4 5 6 7 8 9 10

Foot, Ankle Pain
0 1 2 3 4 5 6 7 8 9 10

Other Pain
_____

Other Concerns
_____
_____
_____
_____
_____

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing/Cutting- |||| Cramping-^^^
Tingling- **::::** Burning- **XXX**
Numbness- === Dull- ###

Please check all of the symptoms that apply. (**P**=Past/**C**=Current)

P/ C	P/ C	P/ C
Headache	Teeth Grinding	Feel Loss of Control
High Blood Pressure	Unpleasant Taste	Irritability
Low Blood Pressure	Excessive Thirst Insomnia	
Abdominal Pains	Elbow/Hand Pain	Impatience
Nausea/Vomiting	Tingling in Hands	Fatigue
Poor Appetite	Clammy Hands Dizziness	
Fullness of Bladder	Shakiness	Forgetfulness
Urination Difficulty	Sweating	Confusion
Frequent Urination	Sore Throat	Other:_____
Constipation	Sinusitis	Other:_____
Hemorrhoids	Blurred Vision	Other:_____
Joint Stiffness	Shoulder Pain	Other:_____
Menstrual Irregularities	Knee Pain	
Decreased Sex Drive	Ankle/Foot Pain	
Swollen Joints	Feel Loss of Control	
Sore Muscles	Swollen Ankles	
Walking Problems	Poor Circulation	

ALLERGIES: Please check and list all allergies/sensitivities

Food:_____
Medications: _____
Seasonal/Other: _____

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Do you have an iodine sensitivity? Y N

MEDICATIONS: **Please check and list all medications that you are currently taking with the date you began taking them.**

	Medication Name	Date Started
Antibiotics		
Antidepressants		
Anti-Diabetics		
Anti-Inflammatory		
Blood Pressure Lowering Meds.		
Cholesterol Lowering Meds.		
Hormone Replacements (HRT)		
Oral Contraceptives		
Other		
Other		

SCARS/SURGICAL PROCEDURES: **List all scars and surgical procedures you have had:** _____

_____

_____

SUPPLEMENTS: **Do you take vitamins/supplements or herbs?** Y N
If yes, which ones and who recommended them? _____

HABITS: Heavy Moderate Light None

Alcohol
Coffee
Soda/Diet Soda
Tobacco
Drugs
Stress Level

5-7x/week 3-5x/wk 1-3x/wk None Type Time

Exercise _____ _____

8+hrs 7-8 hrs 6-7 hrs 5-6 hrs <5 hrs

Sleep _____ _____

5+ 4 3 2

Meals/day _____ _____

64+ oz 32-64 oz 16-32 oz <8oz

Water/day _____ _____

Are you vegetarian/vegan? Y N

WORK ACTIVITY: Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking/Moving Driving
Describe:_____

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(**G**=Grandparents, **M**=Mother, **F**=Father, **S**=Siblings, **X**=Self)

___Alcoholism
___Anemia
___Cancer
___Cold Sores
___Deep vein thrombosis
___Depression
___Diabetes
___Eczema
___Emphysema
___Epilepsy
___Goiter
___Gout
___Heart Disease
___HIV/AIDS
___Miscarriage(s)
___Mumps
___Pleurisy
___Pneumonia
___Polio
___Rheumatic fever
___Stroke
___Tumor(s)
___Ulcer(s)
___Other:_____
_____
_____

Is there anything else that you would like us to know?

_____

_____