Health Solutions Center John Gangemi Chiropractic Physician

Date_____ **Date of Birth**_____

Name _____ **Occupation** _____

Mailing Address_____

Home Phone _____ **Cell**_____

Email_____

How Did You Hear About Our Office _____

Whom May We Thank For Referring You_____

Emergency Contact Name _____ **Best Phone #** _____

Are You Pregnant? _____

What Type Of Treatment 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."

What Type Of Wellness Services Are You Interested in:

□ Pain Relief □ Recover from an Injury □ Structural Balancing □Chiropractic □ Cold Laser Therapy

□ Release & Balance® Method □ Blood Analysis □ Nutritional Counseling □ Weight Loss

□ Laboratory Testing & Analysis □ Stress Relief □ Allergy Relief □ Heavy Metals Testing

□ Vibrational Resonance Therapy

Reason For Todays Visit? _____

Symptoms/ Health Concerns: Please list your top symptoms /health concerns in the order of priority.

1)_____

2)_____

3)_____

When and How Did Symptoms Begin? _____

Do Your Symptoms Interfere With: Work___ Sleep ___ Daily Routine___ Recreation___

Do You Have Pain While: Sitting___Walking___Bending___Standing___Lying down___

Does Anything Make It Better Or Worse _____

Is The Pain: Constant___Intermittent___

Does The Pain Stay In One Area Or Does It Move _____

Rate Your Pain On A Scale From: 1 (least pain) to 10 (most pain) _____

Describe The Pain: Sharp___Dull___Throbbing___Aching___Shooting___Burning___Other_____

Do You Experience: Tingling___ Cramping___Stiffness___Swelling___ Numbness___ Other_____

Please List Any Restricted Range of Motion, Tight & Stiff Muscles _____

Please list Surgeries, Head injuries, Accidents and Dates of Occurrence:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

□ Do you have any tattoos? List locations. _____

□ Do you have any metal surgical implants, plates, bars or pins? _____

□ Have you had facial cosmetic surgery? list location _____

□ Have you had or continue to have facial Botox injections? _____

□ Do you have a pacemaker? _____

ALLERGIES / SENSITIVITIES :

□ Dairy □ Gluten □ Seasonal □ Pollen □ Perfume □ Animals □ Alcohol □ Latex□ Lavender

Please List Any Other Allergies/Sensitivities _____

NUTRITION :

Check All That Apply & Quantity: □Tobacco_____ □Caffeine_____ □Alcohol_____

Do You Take Vitamins/Supplements □Yes □No

GENERAL:

How Would You Describe Your Energy Level □High □ Low □ Average

Do You Have: □High Stress □Anxiety □ Insomnia □Depression

How Would You Describe Your Overall Mood □Happy □Sad □Angry □Frustrated □Mellow □Uptight

Do You Have Heart, Lung, Bowel Or Urinary Problems □No □Yes _____

ls There Anything Else In Your Life History You Would Like To Share With The Doctor?

_____

_____

_____

What Are Your Optimal Health Goals?

_____

_____

MEDICATIONS: Please list current medications, prescription and over the counter.

Name	How Long	For What Condition

Patients Rights & Terms of Acceptance

All communication between doctor and patient in this office is strictly confidential. This office will not discuss or release your information with a third party unless given your written permission to do so. Please also note you have the right to receive and view any information regarding your care at this office.

Initial ____

This office is not an insurance provider. We do not accept any type of insurance coverage.This office only accepts payment in the form of cash, check and credit card. Payment is due when services are rendered unless prior arrangements have been made.

Initial _____

We do not treat any disease or condition other than vertebral subluxation. However if during a chiropractic spinal examination we come across any non-chiropractic or unusual findings we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider that specializes in that area.

Regardless of what the disease or condition is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Initial _____

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I understand there are no guarantee of results. I therefore accept chiropractic care on this basis.

Signature_____Date _____

Print_____