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 #**

<u>What Type Of Treatment Are You Looking For:</u>

- ☐ **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, then go on to “achieve optimal health and wellness.”**

<u>What Type Of Wellness Services Are You Interested in:</u>

☐ **Pain Relief** ☐ **Recover from Injury** ☐ **Chiropractic** ☐ **Therapeutic Laser Therapy**

☐ **Release & Balance® Method** ☐ **Nutritional Counseling** ☐ **Laboratory Testing & Analysis**

☐ **Stress Relief** ☐ **Heavy Metals Testing** ☐ **Life Vessel Resonance Therapy**

Reason For Todays Visit?

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

1)

2)

3)

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?

Are You Pregnant?

Ku'vj gtg'c'j kuqt{ 'qh'Tgvkpcn'Fgvcej o gpvA$

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**

Do You Have: ☐ **High Stress** ☐ **Anxiety** ☐ **Insomnia** ☐ **F gr t guukqp"**

How Would You Describe Your Overall Mood: ☐ **Happy** ☐ **Sad** ☐ **Angry** ☐ **Frustrated** ☐ **Mellow** ☐ **Uptight**

Do You Have Heart, Lung, Bowel Or Urinary Problems ☐ **No** ☐ **Yes**

Is 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

PATIENT INTAKE FORM

Patient Name: Date:

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation

2. Indicate where you have pain/symptoms:

3. How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other:

5. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

7. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER physician ☐ Orthopedist ☐ Other:_____________
☐ Massage Therapist ☐ Physical Therapist ☐ No one

10. How long have you had this problem?

11. How do you think your problem began?

12. Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height Weight Date of Birth

Occupation

16. How would you rate your overall Health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Stenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependance
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee Pain	☐	☐	Abnormal Weight Gain/Loss			
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite			**For Females Only**
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Birth Control Pills
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder			
☐	☐	Cancer	☐	☐	General Fatigue			
☐	☐	Tumor	☐	☐	Muscular Incoordination			
☐	☐	Asthma	☐	☐	Visual Disturbances			
☐	☐	Chronic Sinusitis	☐	☐	Dizziness			
☐	☐	Other:						

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

Sit:	☐ Most of the day	☐ Half the day	☐ A little of the day
Stand:	☐ Most of the day	☐ Half the day	☐ A little of the day
Computer work:	☐ Most of the day	☐ Half the day	☐ A little of the day
On the phone:	☐ Most of the day	☐ Half of the day	☐ A little of the day

24. What activities do you do outside of work?

25. Have you ever been hospitalized? ☐ No ☐ Yes
if yes, why

26. Have you had significant past trauma? ☐ No ☐ Yes

27. Anything else pertinent to your visit today?

Patient Signature **Date:**

Patients Rights & Terms of Acceptance

Release & Balance® Meningeal Release Therapy is a method developed by Dr. John Gangemi, Chiropractic Physician. Meningeal Release and Laser Therapy are considered experimental procedures by the insurance industry and Medicare and, therefore, are not applicable for reimbursement. Initial____

All Payments are due when services are rendered unless prior arrangements have been made. Please ask our staff for a disclosures of fees. Initial____

The fee for your subsequent visits are based on time . Meningeal Release and Photo biotic therapy are combined together in a session and are billed in units of $90 per 30 minutes. Sessions can range from 30 - 90 minutes depending on the problematic issues. This will be discussed in your treatment plan. 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. Initial____

We do not treat any disease or condition other than chiropractic musculoskeletal problems according to the scope of practice for the State of Arizona, 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 treat it. Nor do we offer advice regarding treatment prescribed by others. Our practice objective is to release interference in the nervous system that arises from musculoskeletal spinal-cranial tension. Initial____

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____

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. Initial____

Signature____ Date __________

Print____