

11. Social History (Tell Bluewater Chiropractic about your health habits and stress levels.)

Alcohol use Daily Weekly How much? _____
 Coffee use Daily Weekly How much? _____
 Tobacco use Daily Weekly How much? _____
 Exercising Daily Weekly How much? _____
 Pain relievers Daily Weekly How much? _____
 Soft drinks Daily Weekly How much? _____
 Water intake Daily Weekly How much? _____
 Hobbies: _____

Prayer or meditation? Yes No
 Job pressure/stress? Yes No
 Financial peace? Yes No
 Vaccinated? Yes No
 Mercury fillings? Yes No
 Recreational drugs? Yes No

Patient name _____

12. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. Is there anything else Bluewater Chiropractic should know about your current condition, your progress or ways your current condition is affecting your life?

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Consultation Notes

Signature _____

Date (MM/DD/YYYY) _____

Doctor's Initials _____

**Bluewater Chiropractic
Wellness Center
April W. Lee, D.C.**



UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Your Last Name			Gender <input type="radio"/> Male <input type="radio"/> Female		Today's Date (MM/DD/YYYY)
Your First Name			Your Middle Name (or Initial)		Your Social Security Number
Address			Birth Date (MM/DD/YYYY)		
City			State/Province		ZIP/Postal Code
Email Address			Home Phone		Spouse's Name
Emergency Contact			Cell Phone		Child's Name and Age
Occupation			Phone		Child's Name and Age
Employer			May we contact you at work? <input type="radio"/> Yes <input type="radio"/> No		
Address			Child's Name and Age		
City			State/Province		ZIP/Postal Code
Insurance Carrier			Policy Number		Work Phone
Insured's Last Name			Primary Care Provider's Name		
First Name			Who carries this policy? <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Parent		
Insured's Employer			Middle Name (or Initial)		
Address			Employer's Phone		
City			State/Province		ZIP/Postal Code

I certify that any changes to my personal information have been updated above for your records.

Signature

UPDATED CONTACT INFORMATION