WELCOME TO DR SANTIAGO'S WELLNESS CENTER

Today's Date: _____/_____/_____

Name:_____
Last First MI

Mailing Address: _____
Apt City State Zip

Cell #: (_____)_____ Cell Phone Co: _____

Home #: (_____)_____

Work #: (_____)_____ Ext_____

E-Mail Address:_____

Birthday: _____/_____/_____ Age:_____

Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

SS#: _____-_____-_____

Referred By:_____

Occupation: _____

Insurance Co.: _____

Insured's Name:_____ Relationship: ( ) self ( ) spouse ( ) parent ( )other

Insured's Birthday: _____/_____/_____ Insured's SS #:_____-_____-_____

Please indicate the Intensity and Frequency of your symptoms below:

Intensity: **1 to 3** Mild pain **4 to 6** Moderate pain **7 to 10** Severe pain
Frequency: **D**: Daily **F**: Frequent (3-6 days); **O**: Occasional (1-2 days)

Example: 10 / D Headache. This equals to Sever Daily headaches.

_____/_____ Headache
_____/_____ Right Jaw
_____/_____ Left Jaw
_____/_____ Neck Pain
_____/_____ Upper Back Pain
_____/_____ Lower Back Pain
_____/_____ Chest Pain
_____/_____ Stomach Pain

_____/_____ Right Shoulder Pain
_____/_____ Left Shoulder Pain
_____/_____ Right Elbow Pain
_____/_____ Left Elbow Pain
_____/_____ Right Wrist / Hand Pain
_____/_____ Left Wrist / Hand Pain
_____/_____ Right Arm pain / numb
_____/_____ Left Arm pain / numb
_____/_____ Right Fingers pain / numb
_____/_____ Left Fingers pain / numb

_____/_____ Right Hip Pain
_____/_____ Left Hip Pain
_____/_____ Right Knee Pain
_____/_____ Left Knee Pain
_____/_____ Right Ankle / Foot Pain
_____/_____ Left Ankle / Foot Pain
_____/_____ Right Leg pain / numb
_____/_____ Left Leg pain / numb
_____/_____ Right Toes pain / numb
_____/_____ Left Toes pain / numb

_____/_____ Painful Menstruation
_____/_____ Nervousness
_____/_____ Irritability
_____/_____ Depression
_____/_____ Fatigue
_____/_____ Loss of Memory
_____/_____ Dizziness
_____/_____ Mood Swings
_____/_____ Sinuses
_____/_____ Digestive problems

_____/_____ Fainting
_____/_____ Loss of Balance
_____/_____ Buzzing in Ears
_____/_____ Face Flushed
_____/_____ Loss of Smell
_____/_____ Loss of Taste
_____/_____ Cold Sweats
_____/_____ Shortness of Breath
_____/_____Allergies

_____/_____ Feet Cold
_____/_____ Hand Cold
_____/_____ Constipation
_____/_____ Diarrhea
_____/_____ Fever
_____/_____ Head feels Heavy
_____/_____ Sleeping Problems
_____/_____ Light Bother Eyes
_____/_____Asthma

Please tell Dr. Santiago about your primary problem:

1. What primary location bothers you most? _____

5. When did it start? ( ) Today How many Days ago? ___ Weeks ago? ___ Months ago?___ Years ago?___

2. How did it start? ( ) An injury ( ) Sudden ( ) Gradually

4. How did it happen? _____

3. Where were you when you first felt the pain? ( ) Home ( ) Work ( ) Unknown ( ) Other _____

6. Have you had this problem before? ( ) No ( ) If Yes, when?_____

7. Do you have the problem: ( ) Daily - If so, is it? ( ) 100% ( ) 75% ( ) 50% ( ) 25% of the time
( ) 3 to 6 days per week or ( ) 1 to 2 days per week or less

9. Time of day when the problem is worse? ( )No ( )Morning ( )Noon ( )Evening ( )Night ( )Sleeping

10. What does it feel like? ( )sharp ( )dull ( )achy ( )throb ( )tender ( )heavy ( )numb ( )itchy ( )tingle ( )burn ( )cold

11. What aggravates your problem?

( ) bending	( ) standing	( ) sitting	( ) any prolonged posture	( ) sex	( ) sports
( ) twisting	( ) lying down	( ) walking	( ) standing up from sitting	( ) reaching	( ) exercise
( ) lifting	( ) sleeping	( ) running	( ) climbing stairs	( ) driving	( ) moving

12. What can you do to relieve the pain?

( ) nothing	( ) resting	( ) sitting	( ) walking	( ) ice	( ) wearing a support
( )lying down	( ) sleeping	( )standing	( ) moving	( ) heat	( ) over the counter drugs

12. As a result of having this problem, does it make you feel: ( ) sad ( ) depress ( ) anxious ( ) upset ( ) mad
( ) tired ( ) irritated ( ) tense ( ) nervous ( ) none

13. What activities are limited due to your problem?

( ) nothing	( )squatting	( ) lying down	( ) almost any movement	( ) daily pet care
( ) lifting	( ) stooping	( ) sleeping	( ) repetitive motions	( ) lifting children
( ) pulling	( ) sitting	( ) gardening	( ) changing positions	( ) yard work
( ) pushing	( ) walking	( ) socializing	( ) climbing stairs	( ) concentrating
( ) carrying	( ) running	( ) driving	( ) playing sports	( ) urinating
( )reaching	( ) jumping	( ) working	( ) extended computer use	( ) bathing
( ) twisting	( ) resting	( ) exercising	( ) household chores	( ) brushing teeth
( ) turning	( ) typing	( ) cleaning	( ) daily children care	( ) shaving
( ) bending	( ) cooking	( ) eating	( ) going to the bathroom	( ) dressing
( ) crawling	( ) reading	( ) having sex	( ) caring for infirm family member	( ) putting on socks
( ) kneeling	( ) standing		( ) coughing and sneezing	( ) putting on pants

14. Life Style Interference

A. When this problem is at its worst, does it make it harder to do your job?
( ) are you less productive on your job ( ) enjoy your work less
( ) have to take more breaks ( ) has your boss said anything about it yet

B. When your problems are at their worst, does it affect your relationship with family or friends?
( ) I am less fun to be with ( ) I help less around the house
( ) there are things I cannot do with them Who's more disappointed, ( )You or ( )Them

C. When the problems are at their worst, does this problem affect your sleep?
( ) Trouble falling asleep ( ) Not enough restful sleep
( ) Awakening in the middle of the night ( ) Waking earlier than normally

D. When the problems are at their worst, it prevents me from doing or enjoying hobby/interest/sport?
( )Yes ( )No What? _____

15. What of the following did you tried to do to get rid of the problem, but it did not work?

( ) aspirin	( )medication	( ) massage	( ) wear support / brace	( ) family doctor	( ) neurologist
( ) Tylenol	( ) stretching	( ) ointments	( ) another chiropractor	( ) physical therapy	( ) ignore it, hoping
( ) Advil	( ) exercise	( )heat or ice	( ) acupuncture	( ) orthopedist	it will go away

Name of the above doctors: _____

Do you feel frustrated by having to do the above and the problem still did not go away? ( )Yes ( )No

16. Does this problem make you feel older than you are? ( )Yes ( )No If so, how many years older? _____

18. If this problem did not get fixed, would this problem get worse? ( )Yes ( )No

Any earlier physical traumas: ( ) None

( )1 car accident	( )work injury	( )fall off chair	( )hit head bottom of pool
( )2 or more car accidents	( )sport injury	( )slip and fall	( )carrying weight on your head
( )motorcycle accident	( )fallen off a horse	( )skiing injury	( )in a fight
( )bicycle accident	( )fall off ladder	( )ocean wave injury	Other:

Do think that the above could attribute to the earlier cause of your current problem? ( ) Yes ( ) No

Please let me know about your Current and Past Health History: Please put the letter C in the ( ) for Currently having the condition or a P for having the condition in the Past and it has resolved.

( ) AIDS/HIV	( ) chemical dependency	( ) high blood pressure	( ) polio
( ) alcoholism	( ) depression	( ) low blood pressure	( ) prostate problems
( ) anemia	( ) diabetes	( ) kidney disease	( ) psychiatric care
( ) anorexia	( ) emphysema	( ) liver disease	( ) rheumatoid arthritis
( ) appendicitis	( ) epilepsy	( ) migraine headaches	( ) stroke
( ) arthritis	( ) heart disease	( ) miscarriage	( ) suicide attempt
( ) asthma	( ) hepatitis	( ) multiple sclerosis	( ) thyroid problems
( ) bleeding disorders	( ) hernia	( ) osteoporosis	( ) tumor
( ) breast lump	( ) herniated disc	( ) pacemaker	( ) ulcers
( ) bronchitis	( ) high cholesterol	( ) Parkinson's disease	( ) vaginal infection
( ) bulimia	( ) hypertension	( ) pinched nerve	( ) venereal disease
( )cancer, where_____	( )fractures, where_____	( ) pneumonia	( ) whiplash or obesity

Please let me know your Wellness History and Social History:

Children? ( )N ( )Y # of Children _____	( ) Drinks less than 8 glasses of water daily	( ) Skip breakfast
( ) Pregnant of _____ weeks ( )going through menopause	( ) Drinks 8 glasses of water daily	Take vitamins ( )Y ( ) N
Drinks alcohol? ( )N ( )Y ( )light ( )moderate ( )heavy	( ) Go to the bathroom daily	( ) Poor sleeper
Smoke cigarettes? ( )N ( )Y ( )light ( )moderate ( )heavy	( ) Have trouble going to the bathroom	( ) Good sleeper
Drink caffeine? ( )N ( )Y ( )light ( )moderate ( )heavy	( ) Eats three meals per day	Exercise ( )N ( ) Y

Please let me know what drugs you are currently taking:

( ) none	( ) anti-coagulant	( ) anti-inflammatory	( ) cholesterol	( ) tranquilizers
( ) aspirin	( ) high blood pressure	( ) pain-killers	( ) antibiotic	( ) anti-acid
( ) sleeping pills	( ) anti-depressant	( ) chemotherapy	( ) steroids	( ) codeine

Drugs' Name: _____

What are you Allergic to? ( ) None _____

Please let me know about surgeries you have had: ( ) None

( ) appendectomy, when _____ ( ) tonsillectomy, when _____
( ) hysterectomy, when _____ ( ) caesarian section, when_____
( ) Other: _____ when _____

Please list and date other Hospital stays: ( ) None

Reason: _____Date:_____ Reason: _____Date:_____

Any reason that will prevent you from receiving treatment? ( ) None ( ) Transportation ( ) Work Schedule

Family Health History

1. Under their column put **"C"** for CURRENT health problem.
2. Under their column put **"P"** for a PAST problem.
3. Leave blank those spaces that do no apply.

Condition None:	Father	Mother	Spouse	Brothers	Sister	Child	Child	Child	Child
Arthritis									
Asthma									
Back problems									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disk Problems									
Emotional Problems									
Emphysema									
Epilepsy									
Headache									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Pinched nerves									
Scoliosis									
Sinus trouble									
Stomach Problem									
Other:									

If any of the above family members are deceased, please list their age at death and cause.

_____

_____

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Again, thank you so very much for filling these forms out. Let's get you feeling better!

I understand and guarantee that the above information in this form was completed correctly to the best of my knowledge and Understand it is my responsibility to inform this office of any changes to the information I have provided. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

_____ _____ _____

Patient's Printed Name **Signature** **Date**

_____ _____ _____ _____

Representative's Printed Name **Relationship** **Signature** **Date**