Natural Wellness Care Center

7558 W. Thunderbird Rd., Ste. 4B

Peoria, AZ. 85381

Patient Name: ____ Date: ______________

Address: ________________________________ City, State, Zip: ___________________

Phone: ____________________ Birth Date: _________________ Gender: (Male or Female)

Drivers License #: ______________________________________ Age: ______

Marital Status: ______ Single ______ Married ______ Divorced ______ Widowed

Employer/School Name: ______________________________ Phone: ________________

Address: ________________________________ City, State, Zip: ___________________

Spouse/Parent Name: ________________________ Relationship: ____________________

Address: ________________________________ City, State, Zip: ___________________

Nearest Relative: ________________ Relationship: _____________ Phone: _____________

Who referred you to this office? : ____

- Are your present problems due to an accident or injury? (Yes or No)
- Was the injury:

☐ Personal Injury ☐ Other ____________________
☐ Job Related ☐ Auto Accident

Date of the Accident/Injury: ______________

- Has the accident been reported? (Yes or No)
- If so, to whom?

☐ To Employer ☐ Auto Carrier ☐ Other

List any symptoms you are experiencing today: *Choose the severity associated with the symptom.*

________________ (1) Very Mild (2) Minimal (3) Nominal (4) Mild (5) Moderate (6) Moderately Severe
(7) Acute (8) Severe (9) Very Severe (10) Remarkably Severe

Frequency of Pain: ☐ Occasional ☐ Intermittent ☐ Frequent ☐ None
Type of Pain: (1) Aching (2) Burning (3) Dull (4) Pulling (5) Sharp
(6) Shooting (7) Stabbing (8) Stinging (9) Throbbing (0) None

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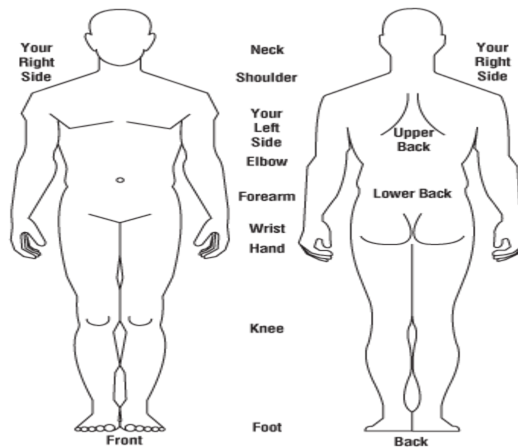
Mark the area of complaint with an "X" on the diagram below:



- If this condition was not related to an accident or injury, how did it develop?

____

- When did the symptoms begin?

____

List any prior treatment, tests, studies or medications received for this condition:

☐ Treatment/Tests/Studies: ____

☐ Medications: ____

- Do you suffer from any condition other than that for which you are consulting us? If yes, describe:

____

- List any past conditions:

____

____

Social History: Habits

☐ Current Every Day Smoker ☐ Occasional Smoker

☐ Former Smoker ☐ Never Smoked

☐ Drinking: Alcohol (Cups/Day) ______ ☐ Coffee (Cups/Day)

☐ Soft Drink (Bottle or Cans/Daily) ☐ Water (Cups/Day)

Exercise:

☐ None ☐ Moderate ☐ Daily

Family History:

	Diabetes	Cancer	Back Pain	Other
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Sibling	☐	☐	☐	☐

Are you taking any medication (prescription or over-the-counter)? ☐ Yes ☐ No

If Yes, please list:

Medication(s): ____

Do you have any allergies? ☐ Yes ☐ No

If Yes, please list:

____

Have you ever had any surgeries? ☐ Yes ☐ No

If Yes, list type of surgery & approximate date:

Type: ______________________ Date: ______________________

Operations and Procedures

Please check the box for each current or past symptom listed.

General Symptoms	**Gastro-Intestinal**	**Eye/Ear/Nose/Throat**	**Respiratory**
☐ Allergy ________________	☐ Belching or Gas	☐ Asthma	☐ Chest Pain
☐ Bronchitis	☐ Colon Trouble	☐ Deafness	☐ Chronic Pain
☐ Headache	☐ Constipation	☐ Earache	☐ Spitting Blood
☐ Convulsions	☐ Diarrhea	☐ Ear Discharge	☐ Spitting Phlegm
☐ Dizziness	☐ Gall Bladder	☐ Ear Noises	
☐ Fainting	☐ Hemorrhoids (piles)	☐ Thyroid Problems	

General Symptoms	**Gastro-Intestinal**	**Eye/Ear/Nose/Throat**	**Genito-Urinary**
☐ Loss of Sleep	☐ Nausea	☐ Nasal Obstruction	☐ Blood in Urine
☐ Loss of Weight	☐ Stomach Pain	☐ Nose Bleeds	☐ Frequent Urination
☐ Nervousness	☐ Vomiting	☐ Pain in Eyes	☐ Urination Control
☐ Night Sweats	☐ Vomiting Blood	☐ Poor Vision	☐ Kidney Infection
☐ Numbness in ______________	☐ Heart Burn	☐ Blurred Vision	☐ Kidney Stones
☐ Wheezing	☐ Bloody Stool	☐ Sinusitis	☐ Painful Urination

Please check the box for each current or past disease listed.

☐ Appendicitis	☐ Anemia	☐ Heart Disease
☐ Arthritis	☐ Pneumonia	☐ Measles
☐ Goiter	☐ Epilepsy	☐ Rheumatic Fever
☐ Mumps	☐ Influenza	☐ Mental Disorder
☐ Polio	☐ Chicken Pox	☐ Pleurisy
☐ Lumbago	☐ Tuberculosis	☐ Diabetes
☐ Alcoholism	☐ Eczema	☐ Whooping Cough
☐ Cancer	☐ Venereal Disease	☐ HIV Positive

Authorization to Treat

I authorize Dr. Hector A. Varela to examine and treat my condition as he deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain in the property of this office, being on file where they may be viewed.

Patient/Guardian Signature: ______________________________ **Date:** ______________

Assignment and Release of Payment

I agree to pay for all chiropractic services. Should collection procedures become necessary, I understand I am responsible for any and all legal expenses, including interest. I authorize the release of any information necessary to process my insurance claim. I authorize payment to Dr. Hector A. Varela directly from my insurance company for all services rendered. Health and accident insurance policies are an arrangement between the carrier and the patient, which are usually designed to offset a large portion of the total cost. The office will prepare any necessary reports and forms to assist in making collections from the insurance company to be paid directly to Dr. Hector A. Varela, which will be credited to the patient's account. It should be understood that all services rendered are charged directly to the patient who is personally responsible for payment. A copy of this authorization shall be as valid as the original.

Patient/Guardian Signature: ______________________________ **Date:** ______________