



11 Maple Avenue
Greenwich, CT 06830
203-637-1111

Date: _____

Patient Number: _____

Whom may we thank for referring you to Greenwich Wellness? _____

Name: _____ Male: ___ Female: ___ Date of Birth: _____

Address: _____ City: _____ Zipcode: _____

Preferred Phone: _____ Secondary Phone: _____

Email: _____

Relationship Status: _____ Partner's Name _____ Children: _____

What type of exercise do you perform on a daily basis? ___ None ___ Moderate ___ Heavy

What do your daily work habits include? (e.g. sitting, standing, light labor, heavy labor, computer work)

Do you smoke? ___ Yes ___ No How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

(For Women) Are you pregnant? ___ Yes ___ No

Please list all medications you are currently taking: _____

Allergies: _____

Are you currently experiencing any symptoms? ___ Yes ___ No

If Yes, please explain:

Where specifically is the problem(s) located? _____

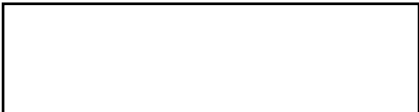
Type of Pain: ___ Sharp ___ Dull ___ Throbbing ___ Numbness ___ Burning ___ Aching ___ Shooting
___ Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other: _____

Rate the severity of your pain on a scale from 1(least pain) to 10(severe pain) ___

Have you been treated by a chiropractor this year? ___ Yes ___ No

Have you seen a doctor for this condition? ___ Yes ___ No

Is this condition getting progressively worse? ___ Yes ___ No



Have you suffered from:

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Backaches |
| <input type="checkbox"/> Digestive Disorders | |
| <input type="checkbox"/> Sinus Trouble | |

Have you ever been in a car accident? Yes No

If Yes, please explain any injuries from the accident:

List any surgeries you have had:

In your own words, what do chiropractors do?

What would you like to gain from coming to our office?

What additional health goals do you have?

DOCTOR'S NOTES ONLY