



HEALTHY HABITS WELLNESS CLINIC, INC.

"Your Health is Our Business"

www.HealthyHabitsWellness.net

14 S. Baltic Place
Meridian, ID 83642
Phone (208) 887-4872
Fax (208) 887-6331

5216 E. Cleveland Blvd., Ste G
Caldwell, ID 83607
Phone (208) 454-8111
Fax (208) 454-8877

CONFIDENTIAL APPLICATION FOR CARE

Name _____ Date _____

Address _____ City _____ ST _____ Zip _____

Social Security Number _____ Date of Birth ____/____/____ Age _____

H Phone _____ Cell Phone _____ W Phone _____

E-mail address _____ # of Children/Ages _____

Marital Status S M D W Spouse's Name _____

Employer _____ Occupation _____

Emergency Contact _____ Phone # _____

Insurance Company Name _____ ID# _____

Name of Insured _____ Date of Birth ____/____/____ Relationship _____

Claim # (if auto or work comp) _____ Contact _____

Your Current Health Habits:

Smoke?	Y	N	packs /day? _____
Drink Alcohol?	Y	N	how often? _____
Take Drugs?	Y	N	how often? _____
Healthy Diet?	Y	N	_____
Exercise Regularly?	Y	N	days / week? _____
Sleep Well?	Y	N	hours / night? _____
Sleep Posture? (circle)			side stomach back
Work/Physical Stress?	Y	N	_____
Emotional/Mental Stress?	Y	N	_____

Are you currently under the care of a medical doctor or other type of health care provider for any condition? Y N If yes, for what condition? _____

Name of doctor/provider _____ Phone # _____

Are you currently on any medications? Y N

Medication/Dose/How Often	Reason for Taking

Are you allergic to any medications? Y N If yes, please list _____

Please list any falls, injuries, broken bones, accidents and surgeries (i.e. sports injury, childhood trauma, auto accident – **please include all**



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Please mark any of the following that you have had with (P) past or (C) current

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Depression | <input type="checkbox"/> Cold/Heat Intolerance |
| <input type="checkbox"/> Neck Pain or Stiffness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Eyes Sensitive to Light | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Allergies/Sinus | <input type="checkbox"/> Weight Loss/Gain |
| <input type="checkbox"/> Pain in Hands or Arms | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Kidney/Bladder Problem |
| <input type="checkbox"/> Numbness in Legs or Feet | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Joint Swelling/Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Stroke | <input type="checkbox"/> Menstruation Problems |
| <input type="checkbox"/> TMJ Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Menopausal Symptoms |
| <input type="checkbox"/> Nervousness/Irritability | <input type="checkbox"/> Diabetes/Hypoglycemia | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Weakness/Fatigue | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Hyperventilation | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Fibro Myalgia | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Please list your reason(s) for this visit or condition in order of importance:	Date you first Noticed:	Using a scale in which "0" is <u>no pain or symptoms</u> and "10" is <u>severe pain or symptoms</u> , circle the number that best reflects your condition:	Please check the box below that best represents how much of the time you feel pain/symptoms for the listed reason:	
		↓none.....to.....severe↓		
		0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
		0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
		0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%

For each of the reasons or conditions listed above, please mark how it happened:

- Developed over time Illness Injury Auto Accident Other _____ I don't know
- Developed over time Illness Injury Auto Accident Other _____ I don't know
- Developed over time Illness Injury Auto Accident Other _____ I don't know
- Developed over time Illness Injury Auto Accident Other _____ I don't know

For each reason listed above, please check if any of the following make your symptom better or worse:

	Heat		Cold		Rest		Activity		Other		Please describe
	<u>better</u>	<u>worse</u>	<u>better</u>	<u>worse</u>	<u>better</u>	<u>worse</u>	<u>better</u>	<u>worse</u>	<u>better</u>	<u>worse</u>	
#1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
#2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
#3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
#4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____



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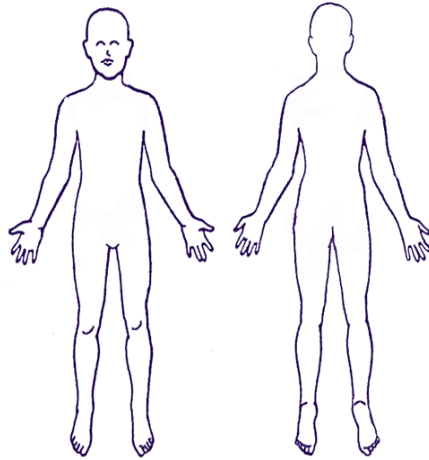
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Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:



/// numbness
v v v dull or aching
o o o pins and needles
+ + + sharp or stabbing

Please check the box that best describes whether your pain or symptom (s) limit normal activities:

Activity	Normal	Somewhat limited	Severely limit
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (listed below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Females Only - # of Pregnancies _____ # of Births _____ Are you possibly pregnant? Y N

Please tell us how you heard about Healthy Habits _____

If by patient referral, please give us their name so we may thank them _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Healthy Habits Wellness Clinic to do whatever is necessary in accordance with this state's statutes, to provide me with chiropractic care.

Patient Signature _____ Date _____

Health Habits Wellness Clinic offers the following discounts for chiropractic clients:

- Family Plan
- Time of Service
- Financial Hardship

Ask if you qualify for any of these special offers.