ARANIBAR

Family Wellness Center

CHIROPRACTIC

Name _____ Date _____

Address _____ City _____ State _____ Zip code _____

Phone # _____ Social Security # _____ Driver Lic. # _____

Age _____ D.O.B. _____ Sex: M / F Status: M / S / D / W No. of children _____

Occupation _____ Employer _____ Years Employed _____

Work phone # _____ Ext. _____ Referred by _____

Do you have Health Insurance? Yes / No

Do you have Chiropractic benefits? Yes / No

Insurance Company name _____ Ins. ID # _____

Subscriber's name _____ DOB _____

Subscriber's employer _____

Relationship to Subscriber: Self / Spouse / Dependent / Other _____

Date problem began: _____ has the pain gotten: Better / Worse / No Change

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present? Constant / Frequent / Occasional

Please describe your problem and how it began: _____

_____

Describe your pain/symptoms: (Circle what pertains to you)	Sharp	Stabbing	Throbbing	Aches
	Dull	Numbness	Soreness	Shooting
	Burning	Tingling	Weakness	Gripping
What makes the pain better? :	Standing	Lying down	Walking	Exercise
	Sitting	Movement	Stretching	Nothing
What makes the pain worse? :	Standing	Lying down	Walking	Exercise
	Sitting	Movement	Stretching	Nothing

What treatment have you had for this condition in the past? (Surgery, medications, injections, therapy, chiropractic) _____

Have you had X-rays, MRIs or other tests for this condition? What tests and When? _____

_____

Patient Signature _____ Date: _____

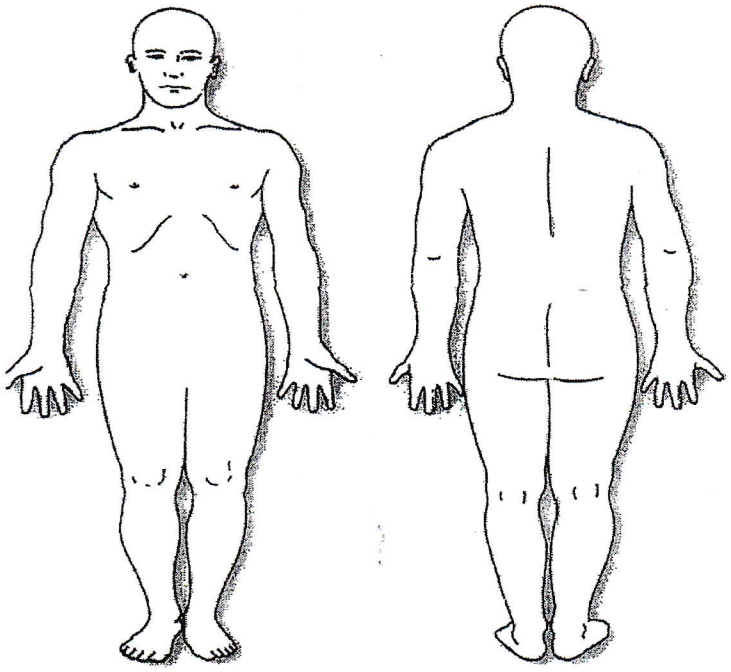
Health History

Do you have any of the following: (Circle the symptoms that pertain to you current or past)

Abdominal pain	Digestive problems	Asthma	Cancer
Rash	Dermatitis	Infection	Blood Disorder
High Blood Pressure	Emphysema	Arthritis	Ulcer
Chest Pain / Conditions	Diabetes	HIV/Aids	Lung Problems
Heart Problems	Headaches	Jaw Pain	Sinus/Allergies
Stroke	Aneurysm	Other_____	

Describe your job requirements: Mainly sitting Light labor Heavy labor

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS, OR TINGLING.



Please read before signing:

I clearly understand and agree that I am responsible for payment of any and all services rendered to me. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. Patients with group or individual insurance are responsible for any unpaid balance in the event their insurance either does not cover chiropractic or is terminated during the treatment.

I, the undersigned, affirm that the above is true and correct, and consent to chiropractic care in this office.

Patients Signature: _____ Date: _____

TOXIC BUILD UP TEST

1. Do you experience fatigue or low energy levels especially around 3pm in the afternoon? **Yes or No**
2. Do you experience brain fog, lack of concentration and/or poor memory? **Yes or No**
3. Do you drink coffee or sodas during the day to "get yourself going"? **Yes or No**
4. Do you smoke cigarettes? **Yes or No**
5. Do you crave or eat sugars, snacks, candies, or desserts? **Yes or No**
6. Do you feel sleepy after meals, bloated, and/or gassy? **Yes or No**
7. Do you experience heart burn or indigestion after eating? **Yes or No**
8. Are you overweight or do you rarely exercise? **Yes or No**
9. Do you eat fast foods, fatty foods, prepared foods, or fried foods on a regular basis? **Yes or No**
10. Do you experience reoccurring yeast or fungal infections? **Yes or No**
11. Do you experience frequent headaches or migraines? **Yes or No**
12. Do you have arthritic aches and pains of stiffness? **Yes or No**
13. Do you take prescriptive medicine on a regular basis? **Yes or No**
14. Do you experience depression or mood swings (mental highs or lows)? **Yes or No**
15. Have you ever used an internal cleansing product or followed a complete internal cleansing program? **Yes or No**

If you answered "yes" to 4 or more of the above questions or answered no to question 15, then you are a good candidate for an internal cleansing program and would greatly benefit from an Ionic Detoxification treatment schedule.