COMPLETE WELLNESS

30 E. 60th Street #302 - New York, NY 10022
www.completewellnessnyc.com
(office) (212) 737-9000 | (fax) (212) 223-5700

(OFFICE USE ONLY)

☐ **New Patient**	Notes:	
☐ **Special Consultation**	For:	

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

Email Address: _____

Social Security #: _____ Referred by: _____

Occupation: _____ Employer: _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** Spouse Name: _____

Number of Children/Ages: _____ Spouses Occupation: _____

Primary Physician Name: _____ Phone #: _____

MAIN PROBLEM

Describe present complaint: _____

What caused the complaint? _____

When did it start? _____ How long does this complaint last? _____

How bad is this complaint? ☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **Intolerable**

Check the word(s) that best describe the complaint: ☐ **Cramping** ☐ **Aching** ☐ **Dull** ☐ **Sharp** ☐ **Shooting** ☐ **Bright** ☐ **Diffuse**

☐ **Lightening-like** ☐ **Throbbing** ☐ **Nagging** ☐ **Burning** ☐ **Deep** ☐ **Stinging** ☐ **Pressure-like** ☐ **Severe** ☐ **Intolerable**

☐ **Other** _____

How often does the complaint occur: ☐ **Occasional** ☐ **Frequent** ☐ **Constant**

Does this complaint travel to any other area? ☐ **Yes** ☐ **No** If Yes, where_____

What makes the complaint worse? _____

What else have you done to treat this complaint? _____

Does this pain: ☐ **Shoot** ☐ **Radiate** ☐ **Travel in your body** Where?_____

Are you experiencing numbness or tingling in any area of your body? ☐ **Yes** ☐ **No** Where? _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

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Is this condition worse during certain times of the day? _____

Is this condition interfering with: ☐ **Work** ☐ **Sleep** ☐ **Routine** ☐ **Other:** _____

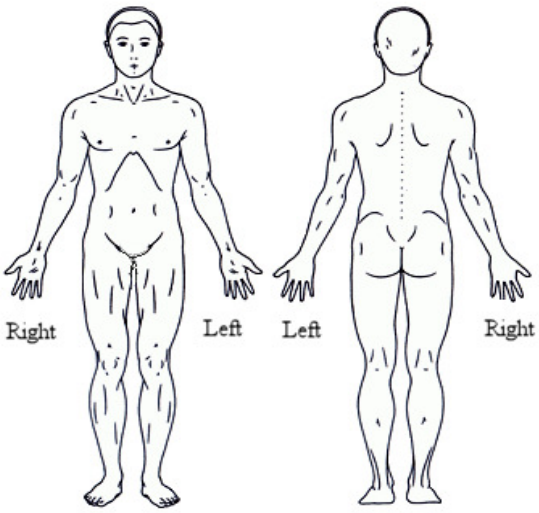
Is this condition progressively getting worse? _____

Other doctors seen for this condition: _____

Any home remedies? _____

Please circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Please check the following conditions/symptoms that you experiencing or have had in the past.

☐ Headaches	☐ Pain in Hands or Arms	☐ Chest Pains
☐ Neck Pain	☐ Tingling/Numbness	☐ Stress
☐ Sleeping Problems	☐ Pain in Legs/ankle or Feet	☐ High Blood Pressure
☐ Lower Back Pain	☐ Anxiety	☐ Nervousness
☐ Upper Back Pain	☐ Fatigue	☐ Loss of Smell or Taste
☐ Tension	☐ Depression	☐ Weight Issue
☐ Irritability	☐ Lights Bother Eyes	☐ Arthritis
☐ Dizziness	☐ Loss of Memory	☐ Diarrhea
☐ Pain between Shoulders	☐ Shoulder Pain	☐ Constipation
☐ Neck Stiff	☐ Sinus	☐ Digestive/Stomach Upset
☐ Joint Swelling	☐ Shortness of Breath	☐ Heartburn/Reflux
☐ Fever	☐ Asthma/Allergies	☐ Muscular Aches
☐ Loss of Balance	☐ Hormone Imbalance	☐ Menopause
☐ Ringing in Ears	☐ Cold Hands/Feet	☐ Menstrual Cramps
☐ Jaw/TMJ Problems	☐ Carpal Tunnel	☐ Other _____

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How long have you suffered these symptoms? ( ) days ( ) weeks ( ) months ( ) years

Have you ever had an accident? ☐ Auto _____/_____ (Mo./Yr) ☐ Work _____/_____ (Mo./Yr)
☐ Other _____/_____ (Mo./Yr) ☐ None

OTHER PROBLEMS

What other complaint do you have? _____

What caused these complaints? _____ Pain or Problem started on: _____

How long does the complaint last? _____

Pains are: ☐ **Mild** ☐**Moderate** ☐**Severe** ☐ **Intolerable** ☐ **Other**_____

Check the word(s) that best describe the complaint: ☐ **Cramping** ☐ **Aching** ☐ **Dull** ☐ **Sharp** ☐**Shooting** ☐ **Bright** ☐ **Diffuse**
☐ **Lightening-like** ☐ **Throbbing** ☐ **Nagging** ☐ **Burning** ☐**Deep** ☐ **Stinging** ☐ **Pressure-like** ☐ **Severe** ☐ **Intolerable**
☐ **Other** _____

Does this pain: ☐ **Shoot** ☐ **Radiate** ☐ **Travel in your body** Where?_____
Are you experiencing numbness or tingling in any area of your body? ☐ **Yes** ☐ **No** Where? _____
Since it began, is it: ☐ **Intermittent** ☐ **Better** ☐ **Worst**

Are you under medical care for any condition? _____

What medications are you taking? _____

How long? _____ Have you had surgery? _____ What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family: _____

Cause of parents or siblings death & age at death _____

	Heart Disease	Arthritis	Cancer	Diabetes	Stroke	Multiple Sclerosis	Other
Father's side	☐	☐	☐	☐	☐	☐	☐ _____
Mother's side	☐	☐	☐	☐	☐	☐	☐ _____

Past and Social History

Previous illnesses you've had in your life: _____

Previous injury or trauma: _____

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Broken any bones? ☐ **Yes** ☐ **No** If Yes, Which? _____

Allergies: _____

Surgeries and dates: _____

Pregnancies, Date of Delivery & Outcomes (Female only): _____

Date of the beginning of your last menstrual period? _____ Any menstrual problems? ☐ **Yes** ☐ **No**

Do you consume alcohol: ☐ **Yes** ☐ **No** If yes, how often? _____

Do you smoke? ☐ **Yes** ☐ **No** If yes, how often? _____

Do you exercise: ☐ **Yes** ☐ **No** If yes, how often? _____

Where: _____Other recreational activities: _____

Do you take any vitamins or supplements? ☐ **Yes** ☐ **No** If yes, how often? _____

Health Insurance

Do you have Medical Insurance? ☐ **Yes** ☐ **No**

Do you have Medicare? ☐ **Yes** ☐ **No**

Do you have Medicaid? ☐ **Yes** ☐ **No**

Insurance Company: _____

Policy Number: _____Group: _____Phone:_____

Insured Name: _____Insured DOB:_____

Phone:_____Street Address: _____

City:_____State: _____Zip: _____

I, _____ hereby certify that the statements and answers given on this form are accurate to the best
Patient Name (Print)
of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature: _____**Date:**_____