GATEWAYS QUANTUM CENTER

Name:_____ Date of Birth:_____ Age:___ Today's Date:_____
Address:_____ City:_____ State:_____ Zip:_____
Cell Phone #:_____ Home:_____ Email:_____
Occupation:_____ Sex: ❑M ❑F ❑_____
Marital Status: ❑Single ❑Married ❑Partnered ❑Divorced ❑Widowed Spouse/Partner's Name:_____
Names & Ages of Children:_____
Emergency Contact:_____ Relationship:_____ Phone #:_____
How did you hear about us?_____
Whom may we thank for your referral?_____
Have you seen a chiropractor before? ❑Yes ❑No Office:_____ Last visit?_____
Reason for Care:_____ Results:_____

Our office provides wellness + embodiment & transformational care ONLY. We are not medical doctors and do not provide diagnosis, examinations, or treatment for medical conditions, complaints, or symptoms, *including pain*. Therefore, we are unable to participate in any insurance or Medicare plans or programs. We do not accept any personal injury or work comp. cases and we will not communicate with any insurance company for any reason due to the non-medical nature of the care we provide. We are unable to offer super-bills, medical coding, or exceptions of any kind to the above policies.

We honor and hold you in your wholeness and honor your symptoms as sacred messengers and important data points for your healing journey. We provide care to help you optimize your wellness, vitality, and experience & expression of Life.

Please initial that you understand and freely choose to apply to become a practice member and, if accepted, you agree to accept these policies. _____

WELCOME!

What is the reason you are seeking care in our office? _____
_____
_____
_____
What are your current health & well-being concerns? (In order of priority)_____
_____
_____

If you could shift/change/improve ONE thing due to care at our office, what would it be? _____
_____

BODY-FOCUSED Care & Questions: **We do not diagnose or treat any symptoms, conditions, or medical issues. These questions are to gather data to better understand your general state of well-being and the historical record of what you + your body & nervous system have been experiencing.*

Do you have any body-related concerns or issues? _____
When did it start? _____❑ Sudden ❑ Gradual ❑ Recurring Describe onset:_____
Describe what it feels like:_____
Please rate the severity: (0=none, 10=worst imaginable): 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Severity at its worst (0-10):_____ Severity at its best (0-10):_____ How often does it occur?_____% of day
When are symptoms the worst?_____ Does it keep you from doing anything?_____
What makes it worse?_____ What makes it better?_____
Describe prior treatment, diagnoses, interventions, or medications used for this problem and their results:_____
_____
Anything else we need to know? _____
_____

HEALTH HISTORY – LET'S START AT THE BEGINNING

Practice Member Name _____ Date of Birth _____

BIRTH: What do you know about your birth? Tell us about your mom's pregnancy with you and your birth story: (vaginal, surgical, duration of labor, medications used, interventions used, weeks gestation, APGAR scores, etc.)

_____

_____

CHILDHOOD: Major life events in your childhood, favorite activities/sports, injuries etc.:

_____

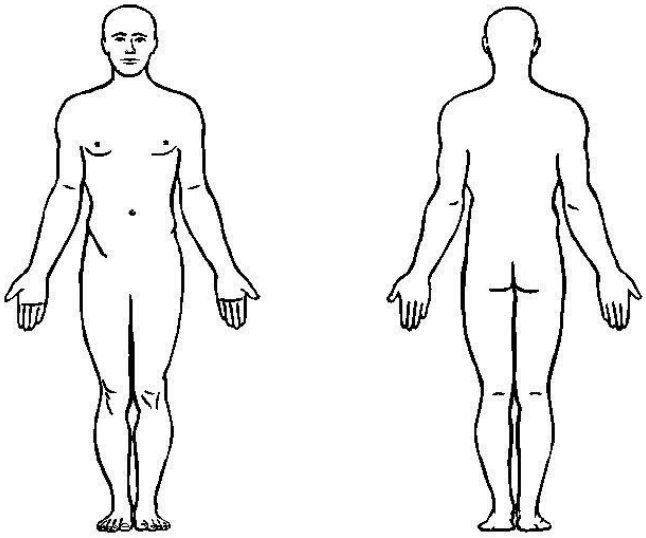
_____

ADOLESCENCE/YOUNG ADULT: Major life events, favorite activities/sports/hobbies, work, etc.:

_____

_____

Where are your scars? (please explain below).



How many siblings do you have? _____

What sports have you played?

_____

What were your hobbies as a child? Today?

_____

Have you ever fallen on your tailbone?

_____

Have you ever had any bone fractures or stitches?

_____

Have you ever fainted? Please describe:

_____

Have you ever had a concussion, head injury, or loss of consciousness? Please describe: _____

_____

Did you experience any major losses or emotional traumas as a child or young adult? _____

_____

SURGERIES (with age/date):

Any pins, screws, implants, or transplanted tissues? ❑Yes ❑No

_____

_____

INJURIES (with age/date): _____

_____

You have 10 organ systems. These systems are used to maintain homeostasis (internal balance) within the body. Have you had any issues, past or current, within any of these systems?

(1) Digestion (esophagus, stomach, bowels):_____
(2) Muscles, bones, joints: _____
(3) Respiratory (lungs, airway):_____
(4) Circulatory (heart, blood vessels):_____
(5) Immune System:_____
(6) Reproductive/Genital:_____
(7) Urinary (kidneys, ureters, bladder): _____
(8) Nervous System (brain, spinal cord, nerves, 5 senses): _____
(9) Skin, hair, nails:_____
(10) Endocrine System (glands, hormones – ex. thyroid): _____

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HEALTH HISTORY

Practice Member Name _____ Date of Birth _____

Have you been diagnosed with any ongoing, unresolved, chronic, recurring health problems? ❑Yes ❑No
Please explain:_____

Are you currently seeing any other healthcare practitioners? Please List:_____
_____

CURRENT MEDICATIONS & SUPPLEMENTS **Include regularly used over-the-counter medications.*

Name of Medication/Supplement	Dosage	Frequency	Reason for Taking	When did you start taking it?

ALLERGIES Please list any allergies you have and your reaction to that substance): ❑ No known allergies
_____

Please check the appropriate box for all symptoms you have, or have ever had, even if they do not seem related to your current problem. (P = Previous) (C = Current) (Blank/Unmarked = Never)

P C		P C		P C		P C	
❑ ❑	Stiff, sore joints	❑ ❑	Diabetes	❑ ❑	Chest pain	❑ ❑	Scoliosis
❑ ❑	Headache	❑ ❑	Asthma	❑ ❑	Pacemaker	❑ ❑	Neck pain
❑ ❑	Heartburn	❑ ❑	Emphysema	❑ ❑	High blood pressure	❑ ❑	Shoulder/arm pain
❑ ❑	Gas, bloating	❑ ❑	Frequent colds/flus	❑ ❑	Low blood pressure	❑ ❑	Numbness in fingers
❑ ❑	Constipation	❑ ❑	Sinus trouble	❑ ❑	High cholesterol	❑ ❑	Cold hands
❑ ❑	Diarrhea	❑ ❑	Epilepsy	❑ ❑	Aneurysm	❑ ❑	Mid-back pain
❑ ❑	Anxiety, irritability	❑ ❑	Multiple Sclerosis	❑ ❑	Bleeding disorder	❑ ❑	Low back pain
❑ ❑	Depression	❑ ❑	Ringing in ears	❑ ❑	HIV/AIDS	❑ ❑	Hip pain
❑ ❑	Restlessness	❑ ❑	Blurred vision	❑ ❑	Menstrual irregularity	❑ ❑	Leg/Foot pain
❑ ❑	Insomnia	❑ ❑	Vertigo	❑ ❑	Miscarriage	❑ ❑	Numbness in legs/feet
❑ ❑	Fatigue	❑ ❑	Stroke	❑ ❑	Infertility	❑ ❑	Cold feet
❑ ❑	Anemia	❑ ❑	Urinary Problems	❑ ❑	Prostate problems	❑ ❑	Osteoporosis/Osteopenia

P C		P C	
❑ ❑	Arthritis (type, where?):_____	❑ ❑	Autoimmune disease:_____
❑ ❑	Skin problems:_____	❑ ❑	Thyroid problems:_____
❑ ❑	Gastric/Bowel disease:_____	❑ ❑	Kidney disease:_____
❑ ❑	Heart disease:_____	❑ ❑	Liver disease:_____
❑ ❑	Respiratory disease:_____	❑ ❑	Genital-Urinary disease:_____
❑ ❑	Cancer:_____	❑ ❑	Nervous system or Vascular disease:_____

FOR WOMEN:

Are you pregnant? ❑Yes ____ weeks, ___ days ❑No Date of Last Menstrual Period:_____
If pregnant, what is your "est. due date"?_____ Name of OB/GYN or Midwife:_____
Where will you be birthing your baby? ❑Hospital ❑Home ❑Birthing Center ❑Other:_____
What are your goals and preferences for your birth? _____
What are you goals and preferences for breastfeeding? _____

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Practice Member Name _____ Date of Birth _____

FAMILY HISTORY

- ❑ Diabetes Mother/Father/Brother/Sister/Other:_____
- ❑ Heart Disease Mother/Father/Brother/Sister/Other:_____
- ❑ Cancer Mother/Father/Brother/Sister/Other:_____ Type:_____
- ❑ Arthritis Mother/Father/Brother/Sister/Other:_____ Type:_____
- ❑ Neurologic Disorders (MS, Parkinson's, ALS, etc.) _____ Mother/Father/Brother/Sister/Other:_____
- ❑ Other:_____ Mother/Father/Brother/Sister/Other:_____

GATEWAYS TO HEALTH

What are your current health & wellness goals (long and short term)?_____

_____

How much do you sleep each night? What time do you usually go to bed? _____

Please tell us what your daily life is like (including work): _____

What about your weekends / 'free'-time? _____

What would your IDEAL daily life look like? _____

Please rate your overall health & wellness: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Please rate your average stress level: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How would you describe your current health?_____

How would you describe your family's health?_____

Is your health better, worse, or the same as 5 years ago? Why do you think this is?_____

What are your major sources of stress?

- ❑ Physical _____
- ❑ Nutritional _____
- ❑ Emotional _____
- ❑ Mental/Intellectual_____
- ❑ Relationships with others_____
- ❑ Spiritual _____
- ❑ Work_____
- ❑ Financial_____
- ❑ Environmental_____
- ❑ Creative Expression _____
- ❑ Sense of Purpose_____
- ❑ Other _____

How do you manage stress/
What are your major sources of joy, fulfillment, support?

- ❑ Physical _____
- ❑ Nutritional _____
- ❑ Emotional_____
- ❑ Mental/Intellectual_____
- ❑ Relationships with others_____
- ❑ Spiritual _____
- ❑ Work_____
- ❑ Financial_____
- ❑ Environmental_____
- ❑ Creative Expression _____
- ❑ Sense of Purpose_____
- ❑ Other _____

NUTRITION

Nutritional guidelines you follow:_____

Food sensitivities (known or suspected):_____

Food allergies:_____ Foods you avoid (and why):_____

Habits: ❑ Smoking (___ packs/day) ❑ Alcohol (____ drinks/day) ❑ Caffeine (type:_____ #/day_____)
❑ Soda ❑ Diet Soda ❑ Artificial Sweeteners ❑ Fast Food