

**Please note: We must receive your completed paperwork at least 1 day prior to your phone consultation. Please fax your completed paperwork to 847-594-5334.
 Thank you!**

Name:				Date:	
Address:					
City:			State:		Zip:
Home Phone:			Work Phone:		
Cell Phone:			Preferred Contact Time:		
Email:					
Fax (work):			Fax (home):		
Age:	Date of Birth:	Sex: M F	Status: M S W D	No. Children:	
Occupation:		Employer:		Yrs Employed:	
Spouses Name:		Occupation:		Employer:	
Person Responsible For Account:			Referred By:		
What is your major complaint?					
Other complaints?					
What are your overall health goals once your complaints are resolved?					
How long has it been since you felt healthy?					

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Cornerstone Health Services to release my personal medical information to me.

Patient's Signature: _____ Date: _____

HEALTH HISTORY

Mark "X" if **YOU** have experienced these conditions/symptoms in the past 12 months.

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Weight Gain or Loss | <input type="checkbox"/> Easily Startled |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eye Trouble | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bursitis/Tendonitis |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Heel Spurs |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excess Gas/Flatulence | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Bloating after meals | <input type="checkbox"/> Rapid Heartbeat | <input type="checkbox"/> Stomach Trouble |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Smoker, Current/Past |
| <input type="checkbox"/> Injuries | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Emotionally Overstressed |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Upper Back/Neck Pain |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Obsessive/Compulsive | <input type="checkbox"/> Low Body Temperature |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Difficult Urination | <input type="checkbox"/> Unexplained Hair Loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Memory Troubles |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Tumors or Lumps | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Dry/Thinning Skin |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Excessive belching |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Vaginal Problems/Pain | <input type="checkbox"/> Low energy |
| <input type="checkbox"/> Gallbladder Trouble | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Abnormal Periods | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Operations: list them | <input type="checkbox"/> Scanty Perspiration | <input type="checkbox"/> Injuries: list them |
| 1. | | 1. |
| 2. | | 2. |
| 3. | | 3. |

Have you ever had previous Chiropractic care? _____ When? _____

Name of your Medical Physician _____ Office Phone Num.: _____

Date of last physical examination _____

Date of your last blood testing _____

What is your heritage? (i.e. Irish, German, Russian, etc.) _____

List your current medications/vitamins (dosage if known) _____

FAMILY:

Please review the conditions listed below and indicate those that **YOUR FAMILY** members have or had previously with and “X”. The bottom of this form may be used for additional information.

CONDITION	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis						
Asthma						
Allergies						
Anemia						
Cancer						
Cholesterol						
Colitis						
Constipation						
Depression						
Diabetes						
Diarrhea						
Eyes						
Fatigue						
Headaches						
Heartburn						
Heart						
Hypertension						
Infertility						
Insomnia						
Kidney						
Liver						
Migraines						
Nervousness						
Sinus						
Skin problem						
Thyroid						
Ulcers						
Weight Gain						

LIFESTYLE

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

Height _____ Weight _____ Blood Pressure _____

PRIMARY HEALTH CONCERNS: _____

Circle Response. Neatly print answers where indicated.

1. Do you experience problems falling asleep? Y or N
2. Do you experience problems staying asleep? Y or N
3. What time do you normally go to bed? _____
4. What time do you normally awaken? _____
5. Do you feel rested upon awakening? Y or N
6. Do you awaken nightly between 2-3 am? Y or N
7. Do you recall your dreams? Y or N
8. Do you frequently have nightmares? Y or N
9. Is your energy good all day? Y or N
If no, what time of day is your energy best? _____
What time is the lowest? _____
10. Do you feel tired all the time? Y or N
If yes, how long have you felt this way? _____
11. Do you suffer from depression? Y or N
If yes, please describe: _____
12. Do you suffer from pain? Y or N
If yes, please explain: _____
13. Are you mentally and emotionally overstressed? Y or N
If yes, how long have you felt this way? _____
14. Do you suffer from low blood sugar? Y or N
If yes, please explain: _____
15. How often do you skip meals? _____
16. Do you eat within 1 hour of awakening? Y or N
If no, how long until your first meal? _____
17. Do you have a bedtime snack? Y or N
18. What time do you typically have your last meal/snack of the day? _____
19. Do you need caffeine (coffee, soda, tea, etc.) to get going in the morning? Y or N
20. Do loud noises bother you? Y or N
21. Are you startled easily? Y or N
22. Do you suffer allergies? Y or N

23. Do you suffer from recurrent/chronic infections? Y or N
24. Do you take thyroid hormones? Y or N
If yes, please list type, dose, and how long you have been taking them.

25. Are you taking other hormones? Y or N
If yes, please type, dose, and how long.

26. Do you suffer from mental confusion? Y or N
27. Do you get chronic headaches? Y or N
28. Do you experience light-headedness? Y or N
29. Have you ever fainted? Y or N
30. Are you easily upset? Y or N
31. Are you taking sleeping pills? Y or N
If yes, please list type, dose, and how long.

32. Are you taking anti-depressants? Y or N
If yes, please list type, dose, and how long.

33. Do you exercise? Y or N
If yes, what type, time of day, how long, and how often. _____

34. Do you feel better or worse after exercising? _____
35. If you are not exercising, is there a reason? _____
36. Do you frequently experience a second wind (high energy) late at night? Y or N
37. What is your daytime light source (i.e. indoor/fluorescent, outdoor/full spectrum)

38. Do you have high blood pressure? Y or N
If yes, are you taking medication? Y or N
If yes, list type, dose, and how long. _____
39. Do you have low blood pressure? Y or N
40. Do you feel nauseous? Y or N
41. Do you have bloating? Y or N
42. Do you get heartburn? Y or N
43. Do you have constipation? Y or N
44. Do you have gas? Y or N
45. Do you belch following meals? Y or N
46. Do your bowel movements alternate between diarrhea and constipation? Y or N
47. Do you have intestinal/abdominal pain? Y or N
48. Do you get bloated after meals? Y or N
49. Do you have diarrhea? Y or N

50. Do you/have you traveled outside the US? Y or N
51. Are your stools compact/hard to pass? Y or N
52. Do you have gurgles in your stomach? Y or N
53. Do you have any known food allergies? Y or N
54. Do you have any cavities/fillings? Y or N
If yes, how many and when _____
55. Have you had any root canals? Y or N
If yes, how many and when _____
56. Have you had any teeth extracted, including wisdom teeth? Y or N
57. Do you have a dental bridge in your mouth? Y or N
58. Do you have TMJ (jaw problems)? Y or N
59. What is your heritage? (i.e. Irish, English, etc.) _____
60. Have you been exposed to environmental and/or chemical toxins?

61. Do you live/have you lived in a home with water damage or mold? (leaky roof, flooded basement, etc.) _____
62. Have you had any head, neck or back injuries? Y or N
If yes, please describe _____

63. What are your hobbies? _____

64. What is your occupation? _____

65. Are you happy in your life right now? _____

66. What are your main sources of stress? _____

67. How do you deal with your stress? _____

7-DAY DIET DIARY

MEAL	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Time: Morning Meal							
Time: Snack							
Time: Noon Meal							
Time: Snack							
Time: Evening Meal							
Time: Snack							
Water Intake							
Exercise Duration							
Relax Duration							

Authorization to Release Medical Information

Please complete this form if you would like us to share information about your progress with another health care professional.

To: (provider) Dr: Christopher Mote

Address: _____

I, _____ request the following information:

Test Results History Records Diagnosis
 Treatment Reports Progress

concerning my: Accident Injury Illness

Other _____

To be released to: _____
(name of Doctor, Insurance co., Attorney, Hospital, Employer, etc.)

Address: _____

Fax: _____

For the purpose of (specify): _____

Signed: _____ Date: _____

Patient Spouse Parent Guardian