Dr. Benjamin Hopsicker
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ALEXANDRIA
WELLNESS CENTER

Name _____ Date_____

Address:

_____

Residence and mailing *City* *State* *Zip* Code

Home Phone ( ) _____Work Phone ( ) _____ Cell Phone ( )_____

E-mail address _____ Male _____ Female _____

Social Security # _____ Birthdate _____ Age _____
(mm/dd/yy)

Occupation/Employer's Name and Address:

_____

_____

Single ☐ Married ☐ Divorced ☐ Widowed ☐

Spouse's Name _____ Spouse's Date of Birth _____
(mm/dd/yy)

Spouse's Occupation/Employer_____

No. of children: _____ Ages: _____

Reason for consulting our office?

_____

Who may we thank for referring you to our office?

_____

Personal Health History:

Please include your childhood years when filling out this portion, as your current health is a result of a lifetime of accumulated stresses.

Prior illnesses: _____

Prior injuries: _____

Prior hospitalizations: _____

Prior surgeries: _____

Any Scheduled/recommended surgeries: _____

Are you currently taking any medications?

Over the counter _____ Purpose _____

Prescription _____Purpose _____

Additional Medications _____

_____

What care have you sought for your complaints in the past?

A. Chiropractic care _____ results _____

B. Medication _____results _____

C. Therapy _____results _____

Family History:

Please describe any major known health conditions that have occurred in your family (including Grandparents, Parents, blood siblings and children)

_____

_____

_____

Chief Complaint:

If you do not have symptoms and are here for a Chiropractic Wellness analysis, please check here _____
If you are here because you have complaints and symptoms, please describe them:
_____

_____

_____

_____

Please circle current Symptoms in the list below
Please check next to symptoms/conditions you have had, even if they seem unrelated to current

Headaches___	Numbness in fingers ___	Fatigue ___	Constipation (chronic) ___
Dizziness ___	Pins & needles in arms ___	Sleeping problems ___	Diarrhea (chronic) ___
Loss of Balance___	Numbness in toes ___	Anxiety ___	Problem urinating ___
Lights bother eyes ___	Pins and needles in legs ___	Depression ___	Nausea (chronic) ___
Ringing in ears ___	Shoulder pain /stiffness ___	Fainting ___	Fever (chronic) ___
Loss of taste ___	Knee pain/stiffness ___	Cold sweats ___	Impotence/loss of sex drive___
Loss of smell ___	Muscle weakness ___	Menstrual pain/irregularity ___	Heartburn ___
Neck Pain/stiffness ___	Cold hands / feet ___	Hot flashes ___	Ulcers ___
Back Pain ____	Other _____		

Did the pain begin **SUDDENLY** _____ or have a **GRADUAL ONSET** _____

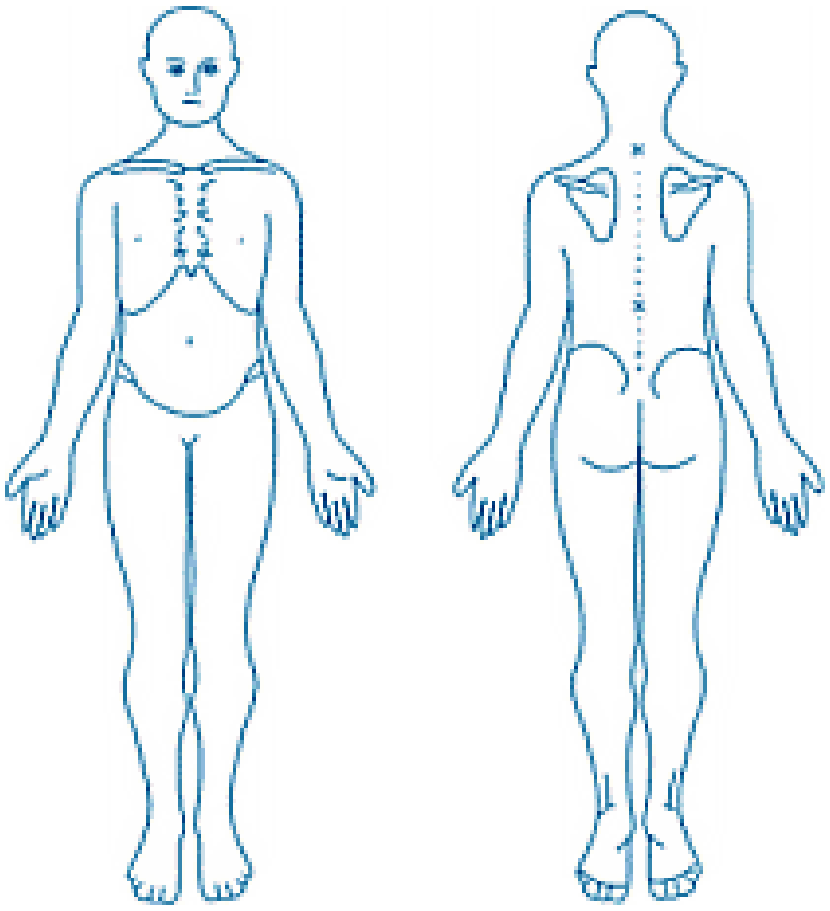
What, if anything, makes your symptoms feel **better?** _____

_____

What, if anything, makes your symptoms feel **worse?** _____

_____

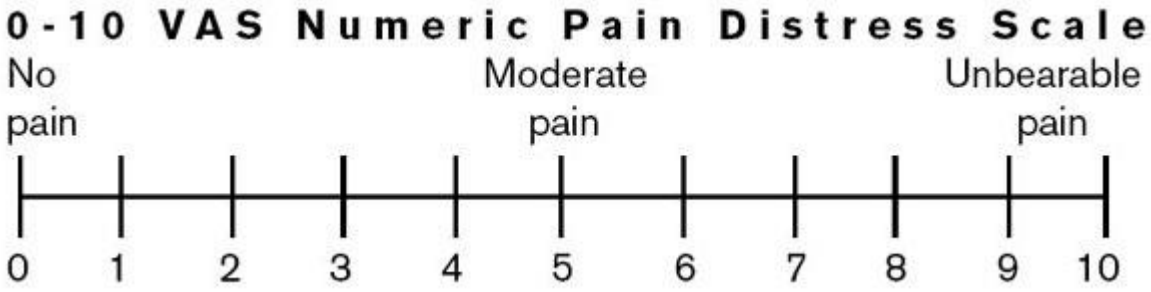
Please mark with X on the diagram below your area or areas of symptoms.
If the pain covers a large area, please circle the area of complaint.
If the pain travels, please draw lines to show where it travels.



Describe your pain (dull, sharp, throbbing, etc.)

_____

Please mark the severity of your pain on the diagram below



What do you believe contributed to your symptoms: (circle all that apply)

Home/yard maintenance Poor Sleep Weight Driving/travel Caring for children Arthritic changes

Computer/office work Prior illnesses Competitive/recreational athletics Occupation

Current/recent pregnancy Sedentary lifestyle Emotional Stress Chemical Stress

Other _____

Please indicate your diminished activities: (circle all that apply)

Home/yard maintenance Sleep Ability to handle Stress Driving/travel Caring for children

Sexual relationships Computer/office work Weight control Exercise Occupational Duties

Other _____

Overall Health Perspective:

The Alexandria Wellness Center is committed to helping you to not just be pain and symptom free, but to **optimize** your health by making you adaptable to the physical, chemical and emotional stressors in your life. Please rate on a scale of 1-5 (1 being poor, 5 being excellent), your personal health levels in the following categories. (please circle your levels).

Nutrition 1 (poor) 2 3 (moderate) 4 5 (excellent)

Exercise 1 (poor) 2 3 (moderate) 4 5 (excellent)

Stress Management: 1 (poor) 2 3 (moderate) 4 5 (excellent)

Friend/Family relationships: 1 (poor) 2 3 (moderate) 4 5 (excellent)

Occupational Satisfaction: 1 (poor) 2 3 (moderate) 4 5 (excellent)

General Well Being: 1 (poor) 2 3 (moderate) 4 5 (excellent)

Successful health care and preventive medicine are only possible when I have a complete understanding of you – including your expectations and obstacles. The nature of your responses to the following questions will go a long way in assisting how I can best help you. Your time, thoughtfulness and honesty in completing this overview are appreciated.

1. What do you know about the Chiropractic approach to health care?

   _____

2. What expectations do you have from **this** visit to our office?

   _____

3. What **long term** expectations do you have from working with our office?

   _____

4. What expectations do you have **of me personally** as your health care provider?

   _____

5. What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? Circle level of commitment:

   0% 1 2 3 4 5 6 7 8 9 10 (100%)

6. What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

   _____

7. What behaviors or lifestyle habits do you currently engage in regularly that you believe are **self-destructive?**

   _____

8. What potential **obstacles** do you foresee in adhering to the treatment recommendations that I will be sharing with you?

   _____

9. Do you feel you are fulfilling your purpose in life? If no, what is standing in your way?

   _____