Beecher Wellness Center

PATIENT INFORMATION

Date: **Name:**

Address:

City: **State:** **Zip:**

Phone Number: **Cell:**

Email:

Birthdate: **Sex:** M ◯ F ◯

Occupation:

Emergency Contact:

I certify that I am the responsible party for this account and I understand that I am financially responsible for all charges. I understand that all charges will be discussed prior to my visit and that my care at Beecher Wellness Center is intended to strengthen and support me and not to treat any individual condition.

Signature:

Beecher Wellness Center For Functional Medicine

Health & Personal History Story

Name _____DOB____/____/____ Current age _____

Address_____

E-mail_____ Preferred Phone Number_____

Please review your life in detail. List as many things as you can remember. This may seem irrelevant or unneeded, but we are trying to understand the whole life story of you, not just the current picture of you.

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*As an infant, my mother breast fed me Y/ N/Unknown * I was vaccinated normally as a child Y/N /Unknown
*Geographical Place Of Birth _____ Moved away when?_____
*Parents age: Mom – (Alive Y / N) age/age of death _____ Dad – (Alive Y / N) age/age of death _____
*How frequent Bowel Movements _____x/week How much water thru day _____
*How many hours sleep per night? _____ How often do you exercise/or are active?_____
*When was the last time you felt good? _____ Any strong viral infection(Mono, herpes, etc) Y N

My List of Genetic health Conditions (From Parents, Grandparemts, or that siblings have)
_____
_____
_____

Chilhood Traumas (physical trauma, mental trauma, death of loved one, surgery, health conditions, etc.)
Include age _____
_____
_____

Adult Trauma's (same as above, include age)
_____
_____
_____
_____

Other Childhood Stressors (A Move, family Divorce, school troubles, etc)
_____
_____

Other Adult Stressors (finances, busy schedule, job, etc.)
_____
_____

Current Health picture

Please list all Symtoms, diseases. Include start dates or diagnosis

List all Medications, Supplements

Current Social interactions (Church, work, friends, etc)

Any additional information you would like to share

Beecher Chiropractic & Wellness Center 428 B Beecher Rd, Gahanna, Ohio 43230 614-855-5533 beecherfrontdesk@yahoo.com

Diet and Goals

How would you describe your diet? (Circle) Flawless Very good Average Poor

Please describe a typical day of eating

_____
_____
_____
_____
_____
_____

Did you eat different in the past? Please explain

_____
_____
_____

What are your goals for you care here? Please use specific examples of activities or accomplishments you would like to achieve.

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

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