**Xu Wellness Center**

235 Germantown Bend Cove

Cordova, TN 38018

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[www.XuWellnessCenter.com](http://www.XuWellnessCenter.com)

**New Patient Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | | Date | |
| Street Address | | Sex | |
| City State Zip | | Date of Birth | |
| Mobile Phone | Marital Status | Height | Weight |
| Mobile Provider | Work Phone | | |
| Home Phone | Maiden/ Former Name | | |
| Email | Primary Physician | | |
| Social Security Number | Driver’s License Number and State | | |
| Occupation | Employer | | |
| Referred by | Other Family Members Seen Here | | |

Emergency Contact Information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone Home Phone Work Phone

**Medical History**

Please list all health complaints/ concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you already seen a physician for these complaints/ concerns? Was there a diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all surgeries and hospital stays; please include the date and procedure:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all significant traumas (auto accidents, falls, broken bones) and dates:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all significant childhood illnesses and/ or injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list ALL allergies, include food sensitivities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under another physician’s care? Why and who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medical conditions from which you suffer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check all symptoms that you experience on a regular basis:

Skin and Hair:

|  |  |  |
| --- | --- | --- |
| * Eczema | * Hair Loss | * Rashes |
| * Hives | * Pimples/ Acne | * Ulcerations |
| * Purpura | * Changes in Hair/ Skin | * Dandruff |
| * Itching | * Psoriasis | * Brittle Nails |
| * Warts | * Hives | * Shingles |
| * Dry Hair/ Skin | * Fungal Infections | * Pale Pallor |
| * Boils | * Painful Scars/ Wounds | * Other: |

Head/ E.E.N.T.

|  |  |  |
| --- | --- | --- |
| * Loss of Smell | * TMJ Pain | * Clicking in Jaw |
| * Poor Vision | * Dizziness | * Blurry/ Double Vision |
| * Concussions | * Nosebleeds | * Sore/ Dry Throat |
| * Migraines | * Glasses | * Sinus Problems |
| * Dry Mouth | * Night Blindness | * Nasal Congestion |
| * Teeth Grinding | * Paralysis | * Glaucoma (Eye Pressure) |
| * Sinus Infections | * Copious Saliva | * Eye Strain |
| * Ringing in Ears | * Teeth Problems | * Facial Pain |
| * Color Blindness | * Poor Hearing | * Sore/ Bleeding Gums |
| * Eye Pain | * Earaches | * Mouth/ Tongue Sores |
| * Cataract | * Loss of Balance | * Bad Taste in Mouth |
| * Spots in Eyes | * Mucus | * Dry Throat |
| * Watery Eyes | * Facial Tics | * Headaches |
| * Hoarse Throat | * Itchy Eyes | * Teeth Loss |
| * Excessive Sneezing | * Loss of Taste | * Teeth Pain |
| * Loss of Strength/ Feeling | * Bad Breath | * Dry Eyes |
| * Difficulty Swallowing | * Excessive Nasal Drip | * Sore Tongue |
| * Frequent Colds | * Other Neck/ Head Problems: | |

Cardiovascular

|  |  |  |
| --- | --- | --- |
| * Chest Pains | * High Blood Pressure | * Low Blood Pressure |
| * Palpitations | * Blood Clots | * Leg Cramps |
| * Irregular Heart Beat | * Fainting Spells | * Swelling in Extremities |
| * Heart Attack | * Heart Disease | * Phlebitis |
| * Pressure/ Tightening in Chest | * Murmur | * Rapid Heart Beat |
| * Spider Veins | * Varicose Veins | * Mitral Valve Prolapse |
| * Pacemaker | * Skipped Heartbeats | * Blood Disorder |
| * High Cholesterol | * Raynaud’s Disease | * Other: |

Gastrointestinal

|  |  |  |  |
| --- | --- | --- | --- |
| * Indigestion | * Nausea | | * Pain/ Cramps |
| * Hemorrhoids | * Vomiting | | * Bad Breath |
| * Rectal Pain | * Irregular BMs | | * Gas |
| * Constipation | * Bloody Stools | | * Recent Weight Loss/ Gain |
| * Belching | * Diarrhea | | * Black Stools |
| * Laxative Use | * Enema Use | | * IBS |
| * Rectal Itch | * Bloating | | * Acid Reflux |
| * Slow Digestion | * Hiatal Hernia | | * Gallbladder Problems |
| * Liver Problems | * Fecal Incontinence | | * Stomachache |
| * Bitter Taste in Mouth | * Colitis | | * Sweet Taste in Mouth |
| * Intestinal Parasites | * Ulcer | | * Stomach Gurgling |
| Number of BMs Daily: | | * Other: | |

Respiratory

|  |  |  |
| --- | --- | --- |
| * Asthma | * Bronchitis | * Difficulty Breathing While Lying Down |
| * Shortness of Breath | * Cough | * Shortness of Breath on Exertion |
| * Seasonal Allergies | * Excessive Phlegm | * Coughing Blood |
| * Emphysema | * Tight Chest | * Chronic Colds |
| * Tuberculosis | * Pleurisy | * Rheumatic Fever |
| * Pneumonia | * Dry Cough | * Wheezing/ Gasping |
| * Whooping Cough | * Sleep with Head Propped up | * Other: |

Endocrine

|  |  |  |
| --- | --- | --- |
| * Thyroid Cancer | * Hypoglycemia | * Adrenal Disorders |
| * Night Sweats | * Hypothyroidism | * Hyperthyroidism |
| * Metabolic Disorder | * Diabetes, type: | * Goiter |
| * Thyroiditis | * Thyroid Hormone Resistance | * Sex Hormone Disorders |
| * Glandular Tumor | * Other: | |

Genitourinary

|  |  |  |
| --- | --- | --- |
| * Bladder Infections | * Urgency to Urinate | * Unable to Hold Urine |
| * Kidney Stones | * Dribble Urine while Sneezing/ Coughing | * Blood in Urine |
| * Painful Sex | * Wake up to Urinate | * Difficulty Starting Stream |
| * Burning/ Pain while Urinating | * STDs: | * Impotency |
| * Frequent Urination | * Kidney Infections | * Bladder Infections |
| * Infertility | * Cloudy Urine | * Wetting the Bed |
| * Weak Urine Stream | * Kidney/ Bladder Pain | * Bladder Reflux |
| * Frequent Urinary Tract Infections | * Other: | |

Gynecological (Women Only)

|  |  |  |  |
| --- | --- | --- | --- |
| * Vaginal Infections | * Breast Lumps | | * Vaginal Discharge |
| * Clots | * Breast Discharge | | * Vaginal Sores |
| * Vaginal Bleeding between Periods | * Vaginal Bleeding (Not with Menses) | | * Painful Menses |
| * Fibroids | * Endometriosis | | * Ovarian Cysts |
| * Vaginal Itching | * Yeast Infections | | * Abortions: |
| * Irregular Menses | * Retain Water | | * Breast Tenderness |
| * Increased Sex Drive | * Decreased Sex Drive | | * PMS |
| * PID | * Changes in Body/ Psyche Prior to Menses | | * Menopausal |
| * Gynecological Surgeries | * Hysterectomy | | * Hot Flashes |
| * Hormone Replacement Therapy | * Recent Change in Menstrual Flow | | * Sexually Active |
| * Gynecological Cancer | * Tubal Ligation | | * Tubal Pregnancy |
| * Birth Control, type: | | | |
| * Currently Pregnant, Month: | | | * Other: |
| * Premature Births: | | * Miscarriages: | |

Date of Last Period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration of Periods:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Pap:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Mammogram:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Pregnancies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Births:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your flow regular, heavy, or light, please explain if unusual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Men Only

|  |  |  |
| --- | --- | --- |
| * Prostate Cancer | * Hernia | * Nocturnal Emissions |
| * Enlarged Prostate | * Loss of Erection | * Prostatitis |
| * Genital/ Jock Itch | * Premature Ejaculation | * Pain in Testes/Penis |
| * Increased Sex Drive | * Decreased Sex Drive | * Low Sperm Count |
| * Groin Pain | * Testitis | * Hair Loss |
| * Testicular Cancer | * Penile Cancer | * Other: |

Musculoskeletal and Neurological

|  |  |  |
| --- | --- | --- |
| * Low Back Pain | * Neck Pain | * Muscle Pain |
| * Joint Pain | * Muscle Spasms/ Cramps | * Muscle Weakness |
| * Paralysis | * Poor Coordination | * Loss of Feeling |
| * Upper or Middle Back Pain | * Numbness/ Tingling: | * Pain Down Legs |
| * Degenerative Disease: | * Diseases/Disorders of the spine | * Brain Tumor |
| * Swollen Joints | * Bone Problems/ Pain | * Osteoporosis |
| * Vertigo | * Stroke | * Genetic Neurologic Disorder: |
| * Arthritis | * Disk Issues | * Fractures |
| * Joint Replacement | * Leg Cramps | * Chronic Pain: |
| * Acute Pain: | * Tremors | * Whiplash |
| * Torticollis | * Gout | * Stiff Neck |
| * Seizures | * Concussion | * Poor Memory |
| * Sprains/ Strains | * Noisy Joints | * Other: |

If you are experiencing pain, please describe frequency, duration, and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychological/ Emotional/ Sleep

|  |  |  |
| --- | --- | --- |
| * Depression | * Bad Temper | * Mood Swings |
| * Wakens Easily | * Anxiety | * Easily Stressed |
| * Considered Suicide | * Attempted Suicide | * Unable to Fall Asleep |
| * Unable to Stay Asleep | * Feelings of Unhappiness | * Poor/Restless Sleep |
| * Insomnia | * Heavy Sleep | * Excessive Worry |
| * Easily Overwhelmed | * Excessive Fears | * Difficulty making Decisions |
| * Nightmares | * Obsessive Tendencies | * Inability to Focus |
| * Unmotivated | * Optimistic | * Pessimistic |
| * Hyperactivity | * Other: | |

If you have been diagnosed with a psychological/ emotional problem, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other

|  |  |  |
| --- | --- | --- |
| * HIV/ AIDS | * Fibromyalgia | * Chronic Fatigue Syndrome |
| * Hepatitis | * Drug/ Alcohol Addiction | * Cancer: |
| * Strong Cravings | * Cold Back | * Strong Thirst |
| * Prefer Cold Drinks | * Prefer Hot Drinks | * Cold Abdomen |
| * Fevers | * Peculiar Tastes/ Smells | * Sweats Easily |
| * Excessive Sweating | * Sudden Drop in Energy | * Overall Poor Condition |
| * Lumps/ Bumps | * Chills | * Cold Hands |
| * Lack of Perspiration | * Bleed/ Bruise Easily | * Anemia |
| * Cold Feet | * Fatigue | * Bleed Excessively When Cut |
| * Heavy Appetite | * Poor Appetite | * Change in Appetite |

Describe your overall energy level:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Medical History

Has anyone in your family suffered from the following?

|  |  |  |
| --- | --- | --- |
| * Diabetes | * Asthma | * Cancer: |
| * Seizures | * High Blood Pressure | * Heart Disease |
| * Stroke | * Allergies | * Obesity |
| * Alcoholism | * Thyroid Problems | * Arthritis |
| * Psychological/ Emotional Problems | * High Cholesterol |  |

Lifestyle

Average Daily Diet

Breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Habits/ Please Include Amount

|  |  |  |
| --- | --- | --- |
| * Cigarettes/ Per Day? | * Coffee/ Per Day? | * Tea/ Per Day? |
| * Alcohol/ Drinks Per Week? | * Sugar/ How Often? | * Table Salt/ How Often? |
| * Fatty Foods/ How Often? | * Soda/ How Often? | * Drugs/ How Often? |
| * Other/ Frequency? | | |

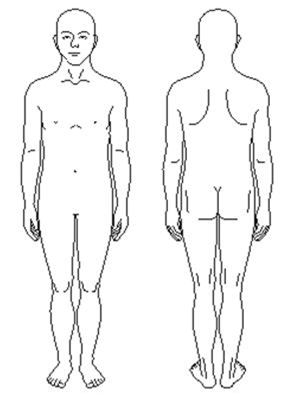
Do you exercise regularly? If so, what type and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much water do you drink daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication List**

Please list all prescription and non-prescription medication, along with any vitamins, herbs, and supplements that you are currently taking.

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| --- | --- | --- | --- |
| Medication/ Supplement | Dose | How Long? | How Often? |
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Please place an X on your problematic areas.

Notes:

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**Informed Consent**

The above information is true to the best of my knowledge. I understand that I am financially responsible to Xu Wellness Center for payment at time service is rendered. I authorize Xu Wellness Center to contact me at the above contact information. I understand that I am responsible for all returned checks and must pay the price on the check plus a $30 bounced check fee. I understand that my personal information is private and will not be shared with anyone unless a written request is made to Xu Wellness Center written and signed by me.

It is my responsibility to inform Xu Wellness Center if any changes in my health occur. I am responsible for informing Xu Wellness Center of any and all health conditions, diseases or disorders from which I suffer. Serious health conditions or injuries will be referred to the appropriate physician, clinic, or hospital. I understand that I still need to continue any medical treatment that I am currently receiving.

I voluntarily consent to being treated by the medical staff at Xu Wellness Center in any of the following ways:

* Patient Health Evaluation/ General Medical Issues
* Bio Identical Hormone Replacement Therapy
* Lyme Disease
* Prolotherapy
* Allergy/ Sinus Issues
* IV Vitamin Therapy
* Injectable Vitamin Therapy
* Impulse Adjustment/ Chiropractic

I understand that I have the right to refuse treatment at any time, and I have the right to end my treatments at any time. I also understand that I have a right to ask whatever questions I have before, during, or after my treatments. I understand that Xu Wellness Center is not to be held responsible for any unexpected complications that may occur, and I understand that results are not guaranteed.

**I voluntarily consent to being treated by the medical staff of Xu Wellness Center, and I understand the treatment or treatments that I am about to receive. I have read this consent form, and I completely understand what I am signing. I consent to be treated at Xu Wellness Center, and I agree to abide by all terms and conditions before mentioned.**

**Patient Signature X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_

If under 18/ Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Doctor’s Use Only

Progress Notes

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