DocJackie New Client Wellness Intake

Alternative Health and Wellness Center

Wellness For ALL Walks of Life!™

Your Information

Today's date: _____

Name: _____

Phone: _____

Email: _____

Address: _____

_____

□ Male □ Female Marital status? _____

Height _____ Weight _____

Emergency Contact

Name: _____

Phone: _____

History:

Any problems with or recent changes in . . . ? Check all that apply.

□ Headaches / Migraines / Dizziness

□ Heart / Chest / Lungs

□ Blood pressure (high or low)

□ Poor circulation (numbness/tingling)

□ Swollen Feet / Varicose Veins

□ Eyes / Vision

□ Depression / Anxiety / Stress

□ Sleeping Difficulty / Tiredness / Fatigue

□ Blood Sugar Issues

□ Dizziness / Fainting

□ Mouth / Teeth / Gums / Tongue

□ Digestive / Gastrointestinal Issues

□ Hormonal Issues (thyroid, etc.)

□ Hair

□ Genito-Urinary Issues

□ Skin Conditions

□ Bacterial / Viral Infections (warts, athletes foot)

□ Regular Colds and Flu / Nose / Throat

□ Mental Issues

□ Epilepsy / Nerves

□ Cancer

□ Other: _____

- continued next page -

Any Accidents / Fractures / Closed Head Injuries? If so, please list.

Any surgeries? If so, please list.

Any childhood illnesses of note?

Any other medical issues I should be aware of?

List any medications and supplements you take:

- continued next page -

Do you sleep primarily on your? □ Side □ Back □ Stomach □ Roll Around

Do you use a pillow . . . □ Under you head? □ Behind your neck?

□ Under your legs or knees □ Between your legs?

Do you use / consume any of the following?

Tobacco:	□ never	□ occasionally	□ frequently
Sodas:	□ never	□ occasionally	□ frequently
Energy drinks:	□ never	□ occasionally	□ frequently
Coffee:	□ never	□ occasionally	□ frequently
Tea:	□ never	□ occasionally	□ frequently
Alcohol:	□ never	□ occasionally	□ frequently
Recreational drugs:	□ never	□ occasionally	□ frequently

What forms of exercise do you enjoy?

How did you hear about DocJackie?

– Please continue to the Self-Assessment and Consent on the next page –

DocJackie Initial Visit Self-Assessment:

Alternative Health and Wellness Center

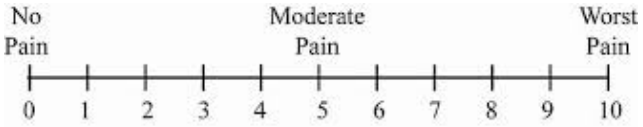
Wellness For ALL Walks of Life!™

In a few words, please describe the reason for your appointment:

Do you have any pain? If so, please mark any that apply.

□ I am not in pain. □ My pain is Acute / Recently started. □ My pain is Chronic / Ongoing for > 2 wks.

On a scale of 0-10, please rate your pain:



Does your pain / discomfort / injury affect your daily activities? Work? Social activities? If yes, please describe.

Client Acknowledgement and Consent

I acknowledge that DocJackies is a licensed chiropractor in the state of Texas. □ yes □ no

I acknowledge that I have stated all my known medical conditions and answered all questions honestly. I also agree to keep DocJackie updated of any changes in my condition. □ yes □ no

I acknowledge that a DocJackie session, in rare cases, could lead to a temporary feeling of lightheadedness, energy or emotional highs and lows, achy joints and/or sore muscles. □ yes □ no

I understand and accept that appointments cancelled less than 24 hours from the time of the appointment will incur a charge of 50% of the full consultation fee. □ yes □ no

I understand and accept that DocJackie does not accept insurance. □ yes □ no

I understand and accept that consultation fees must be paid at the time of the consultation, and can be paid by cash, check, credit card, Venmo, PayPal or Zelle. □ yes □ no

I understand by signing my name in the box below, I am acknowledging my consent to wellness treatment by DocJackie.

Signature

Date Signed

Client Name _____ Date _____

For DocJackie's Use :

Initial Visit: :

Alternative Health and Wellness Center

Wellness For ALL Walks of Life!™