

New Patient Paperwork

Name:				Date:	
Address:					
City:			State:		Zip:
Home Phone:			Work Phone:		
E-mail:					
Age:	Birth date:	Sex: M F	Status: M S W D		No. Children:
Occupation:		Employer:			Years Employed:
Spouse's Name:		Occupation:		Employer:	
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 really felt good?					

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 Asula Chiropractic and Wellness Center to release my personal medical information to me.

Patient's Signature: _____

Date: _____

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight:	Height:	Blood Pressure (if known):	% Body Fat (if known):
1. Are you presently taking any medications, nutritional supplements or vitamins?			
If yes, for how long?			
2. In the past, have you used birth control pills and/or antibiotics?			
If yes, for how long?			
3. If you have fillings, please list material(s) used:			
4. How much sleep do you get each night on average?			
5. Diet. What do you typically eat for:			
Breakfast:		Time:	
Lunch:		Time:	
Dinner:		Time:	
Snacks:		Time:	
Drinks:		Time:	
6. Do you have any food allergies, sensitivities or restrictions?			
7. Smoke cigarettes: #/day: _____ . Other tobacco: #/day: _____ .			
Exposed to second hand smoke or pollution:		Chemicals at work or hobbies	
Alcohol:	Wine # of glasses/day/week:	Liquor # of ounces/day/week:	Beer # glasses/day/week
Caffeine:	Coffee cups/day:	Tea cups/day:	Soda cans/day:
Chocolate or other sweets: ounces/day/week:			
Water:	Glasses/day:	Bottled or Filtered?	
Exercise:	Type:	Frequency:	
8. Please list foods you tend to overeat or crave (sweets, breads, fatty foods, meats, milk, etc.):			

9. Are there foods that you eat on a daily basis, or almost daily basis?						
a. Do you “miss” these foods if you do not eat them?						
10. Write briefly about your weight gain/loss history:						
a. What do you feel triggered your weight fluctuation? (circle):			Hereditary	Stress	Eating habits	Boredom
b. Was your weight gain/loss: (circle)		Sudden	Gradual	Problem since childhood		
c. What methods have you tried to lose/gain weight?						
11. How is your energy level? (circle)		Very Low	Low	Average	Excellent	Highs and Lows
a. Are there times in the day that you feel best?				b. Worst?		
12. Are you happy in your life right now?						
13. What are your main sources of stress?						
14. How do you deal with your stress?						

15. Please answer the following questions Yes or No (circle).

- ❖ If I’m feeling down, a snack makes me feel better. Yes No
- ❖ I sometimes have a hard time going to sleep without a bedtime snack. Yes No
- ❖ I get tired and/or hungry in the mid-afternoon. Yes No
- ❖ I get a sleepy, almost “drugged” feeling after eating a meal containing bread, pasta or dessert. Yes No
- ❖ Now and then I think I am a secret eater. Yes No
- ❖ At a restaurant, I almost always eat too much bread before the meal is served. Yes No
- ❖ I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes No
- ❖ I experience cravings for sugar, breads, pasta and baked goods. Yes No
- ❖ I feel shaky if I don’t eat on time or if I don’t snack. Yes No
- ❖ I often find myself irritable or angry. Yes No

16. Please list close relatives that have Diabetes, Heart Disease, Cancer, Blood Pressure, Circulatory Problems, Stroke, Osteoporosis, Arthritis, Rheumatoid arthritis, Lupus, Mental Illness of Depression, Auto-immune Disorders, Asthma, Allergies, Alcoholism, Drug Abuse, or Obesity:

17. Symptoms **Circle** those you PRESENTLY have (last few weeks). **Underline** those you have had PREVIOUSLY.

GENERAL

Headache
Fever
Chills or Sweats
Fainting or Dizziness
Imbalance
Seizures or Epilepsy
Sleeping Difficulties
Quality of Sleep _____
Sleep _____ hrs/night
Fatigue or Feel run-down
Hypoglycemia
Nervousness/Anxiety
Panic Attacks/Phobias
Depression
Mental Disorder
Alcohol/Drug Problems
Diabetes
Neuralgia
Anemia
Cancer
Memory Loss
Weight Loss _____ lbs
Weight Gain _____ lbs

EAR, NOSE & THROAT

Eye Strain/pain
Failing Vision
Blurred Vision
Glaucoma
Sensitivity to Light
Hearing Problems
Ear noises
Ear infections
Sinus Infections/frequent colds
Nose Bleeds
Sore Throat
Thyroid conditions
Mouth Sores
Gum Disease
Teeth Grinding
Jaw Pain
Tonsillitis
Enlarged Glands
Hay Fever
Allergies

SKIN

Rashes
Skin Eruptions
Eczema
Itching
Bruise Easily
Dark Circles Under the Eyes
Boils
Moles
Varicose Veins
Hair Loss

RESPIRATORY

Asthma
Pneumonia
Emphysema
Tuberculosis
Bronchitis
Chronic Cough
Spitting Blood/Phlegm
Chest Pain
Difficulty Breathing
Shortness of Breath

CARDIOVASCULAR

Rapid/Slow/Irregular Heartbeat
Blood Clots
High or Low Blood Pressure
High Cholesterol
Pacemaker
Hardening of Arteries
Swelling of ankles
Poor Circulation
Stroke/TIA

MUSCLE & JOINT

Stiff neck
Backache
Arthritis
Swollen Joints Bursitis
Tendonitis
Muscle or Joint weakness or pain
Muscle spasms or cramps
Foot Trouble
Spinal Curvature
Osteoporosis

GENITOURINARY

Frequent Urination
Night Urination
Painful Urination
Blood/Pus in Urine
Kidney Infection or stones
Bed Wetting or Incontinence
Prostate Trouble
Hernia
STD
Sexual Dysfunction

GASTROINTESTINAL

Trouble Swallowing
Bad Breath or Body Odor
Indigestion/Heartburn
Nausea
Poor Appetite
Belching or passing gas
Excessive Hunger
Cravings
Hypoglycemia
Eating Disorder
Vomiting Blood
Pain Over Stomach
Ulcers
Distension of Abdomen
Constipation
Diarrhea
Appendicitis
Tiredness after meals
Gurgles in Stomach
Alternating constipation/diarrhea
Hemorrhoids
Parasites
Hepatitis
Gall Bladder Trouble
Bloating After Meals
Liver trouble
Hard/Compact Stools

WOMEN ONLY

PMS
Painful Menstrual Period
Excessive Flow
Bleeding Between Cycles
Irregular Cycle
Cramps or Backache
Endometriosis
Ovarian Cysts
Uterine Fibroids
Abnormal PAP
Vaginal Discharge
Breast Pain/Tenderness
Lumps in Breast
Menopausal Symptoms
Hot Flashes

IS YOUR LIFE:

Satisfactory
Boring
Demanding
Unsatisfying

DO YOU WORRY OVER:

Home Life
Marriage
Children
Job
Finances

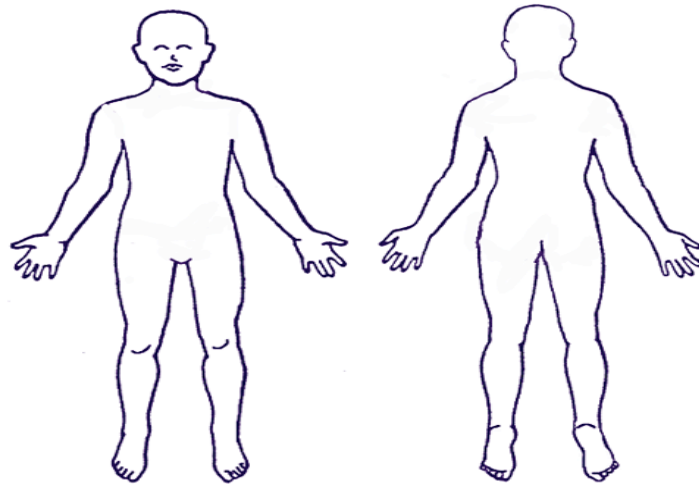
DO YOU OFTEN:

Feel Upset or Cry
Feel Anxiety or Have Irrational Fears
Feel Depressed
Feel Things Always go Wrong
Feel Shy or Inferior
Feel Angry

HAVE YOU:

Seriously Considered Suicide
Attempted Suicide
Suffered Abuse (physical, sexual, or emotional)

18. List any Auto Accidents you've been in:	
19. Surgeries, starting with most recent:	
20. Hospitalizations:	
21. Have you had any recurring infections or inflammations? (For example: bladder, ear, vaginal, sinusitis)	



Please indicate location of pain.

Other than the health concerns already indicated, circle any of the following with which you would like support.

- | | | |
|-----------------------------|------------------------|--------------------------|
| ❖ Have more energy/vitality | ❖ Slow premature aging | ❖ Be less depressed |
| ❖ Sleep better | ❖ Be stronger | ❖ Need fewer drugs |
| ❖ Be less tired | ❖ Be more flexible | ❖ Be less moody |
| ❖ Get less colds/flu | ❖ Reduce body fat | ❖ Think more clearly |
| ❖ Get rid of allergies | ❖ Improve skin | ❖ Improve my memory |
| ❖ Have more sex drive | ❖ Be happier | ❖ Learn to reduce stress |

Asula Chiropractic and Wellness Center

Dr. Laila Nematbakhsh

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drlailahc@gmail.com

THIS FORM IS REQUIRED BY LAW AND SERVES TO PROTECT YOUR RIGHT TO PRIVACY.

Asula Chiropractic and Wellness Center protects the privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, or telephone number. Asula Chiropractic and Wellness Center will not disclose this information without your authorization, except as permitted by law.

Our **Notice of Privacy Practices** provides information about how your protected health information may be used or disclosed. You have the right to request that we restrict how protected health information about you is used or disclosed. Please review the Notice of Privacy Practices before signing this consent.

By signing this form, you consent to our use and disclosure of your protected health information as indicated in the Notice of Privacy Practices. Please note that your personal information is **not** shared with third parties such as financial, credit, or marketing companies. Use is restricted to procedures that are relevant to your care.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Print name

Signature

Date

Asula Chiropractic and Wellness Center

Dr. Laila Nematbakhsh
Phone: (503) 719-5335 - Fax: (503) 719-5334
drlailahc@gmail.com

PAYMENT AUTHORIZATION

I, (print name) _____ authorize Asula Chiropractic and Wellness Center, located at 1828 NW Overton, Portland Oregon to bill my credit card as listed below.

Name on Credit Card:

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Credit Card Holder's Billing Address (Where your statement is mailed):

Credit Card Details:

VISA Card #:	Exp. Date:
MasterCard #:	Exp. Date:
Amex Card #:	Exp. Date:

Last 3 digits (4 for Amex on front) on back of card _____
(found on the back of your credit card on the signature panel)

Authorization

Card Holder's Signature

Today's Date

Patient's Signature

Today's Date

This authorization may be revoked at any time when the following stipulations have been performed:

1. Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.

Asula **Chiropractic and Wellness Center**

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I _____ have read and understood
(please print name)

Asula Chiropractic and Wellness Center Policies and Procedures.

Date _____