Northview Wellness Center
4635 NE Stallings Dr, Ste. 106
Nacogdoches, Texas 75965
936-560-2405 ph. 936-564-3401 fax

Name _____ Date _____
Address _____City _____ State _____ Zip _____
Phone (____) _____ S/S #_____ Driver Lic. # _____
Age_____ Birth date_____ Sex_____ Status: M S W D # children_____
Occupation_____ Employer _____ Years Employed_____
Employer's Address_____ City_____State_____ Zip_____
Spouse's Name_____ Occupation _____Employer _____
Email Address _____ Race_____ Ethnicity: Non-Hispanic/Hispanic
Who referred you to our office? _____
What is your **major** complaint? (in detail)_____
_____
Other complaints _____
List you top five health concerns 1)_____ 2)_____ 3) _____ 4) _____ 5) _____
How long have you had this condition? _____ Have you had this or similar conditions in the past? ____
What activities aggravate your condition? _____
Is this condition getting progressively worse? □ Yes □ No □ Constant □ Comes and goes
Is this condition interfering with you're: □ Family □ Hobbies □ Work □ Sleep □ Daily Routine?
Describe how you feel about this interference _____
When was the last time you felt really good? _____ Surgical operations? _____
Are you taking any medications? _____ Which ones? _____
Any non-prescription drugs? _____Which ones? _____
OTHER DOCTORS SEEN FOR THIS CONDITION: □ M.D. □ D.C. □ D.O. □ D.D.S.
Doctor's Name _____ Diagnosis _____ Did it help? _____
X-rays/CT/MRI _____Urinalysis _____Blood Tests _____Other _____
Treatment: Medications_____ Physical Therapy _____
Were you off work? ___ How long? _____Did you return to the same job? ___ If not, why? _____
What else have you tried that has not worked? _____

HABITS

Currently Smoke? _____ How much? _____ Used to Smoke _____
When did you quit smoking? _____ Never smoked _____
Currently Drink Alcohol? _____ How much/often? _____ Used to Drink _____
When did you quit drinking? _____ Never drank alcohol _____
Currently Drink Coffee? _____ How much/often? _____
Currently Drink Soft Drinks? _____ How much/often? _____
Currently Drink Water? _____ How much/often? _____

ALLERGIES

Do you currently have any allergies? □ Yes □ No
Medication Allergies? _____
Food Allergies? _____
Grasses/Pollens? _____
Animals? _____
Other? _____

EXERCISE

Currently Exercise? _____ How often? _____ How do you exercise? _____
_____

FAMILY HISTORY

Illnesses on Mother's Side? _____ Who? _____ What? _____
Who? _____ What? _____
Illnesses on Father's Side? _____ Who? _____ What? _____
Who? _____ What? _____
Illnesses of Siblings? _____ Who? _____ What? _____
Who? _____ What? _____

INSURANCE INFORMATION:

Are you covered by Medicare? □ Yes □ No Medicare #_____
Do you have any group, union, or personal health and accident insurance? □Yes □ No
Name of Insurance Co. _____ Group # _____ Policy # _____
Address _____ Phone _____ Agent _____
Primary Insured's Birth Date _____ Primary Insured's SS# _____
Is your condition due to an accident or illness? □ Yes □ No □ Other _____

Secondary Insurance Co. _____ Group# _____ Policy # _____
Address _____ Phone _____
Primary Insured's Birth Date _____ Primary Insured's SS# _____

ACCIDENT INFORMATION: (Fill out if you were involved in a work, auto or personal injury accident.)

Did your accident occur while at work? □Yes □ No Were you involved in an auto accident? □ Yes □ No
Date _____Time_____Injury reported to employer? □ Yes □ No Supervisor _____
Description of accident _____
How were you injured? _____
Location of injury _____
Were you unconscious? Y/N □ Fractures □ Cuts □ Abrasions □ Bruises Work Restriction □ Yes □ No
Patient taken to _____ Hospital for _____ treatment.
Confined to hospital for _____ Days, _____ Hours. Name of hospital doctor: _____
Have you had any other personal injuries or accidents? □ Past year □ Past 5 years □ Over 5 years □ None
Describe: _____
Do you have an attorney? □ Yes □ No Name and Address: _____

Patient Signature: _____ Date: _____

Parental Consent to Treat a Minor

I hereby authorize Dr. Scott Sims and whomever he may designate as his assistants to examine and administer treatment as he so deems necessary to my child, _____.

Dated at Northview Wellness Center this _____day of _____ 20_____.

Signed: _____
Parent or Legal Guardian

Northview Wellness Center
Scott Sims, D.C., A.C.N., F.I.A.M.A.
4635 NE Stallings Dr., Suite 106, Nacogdoches, Texas 75965
Phone (936) 560-2405 -- Fax (936)564-3401

Name: _____ Date: _____

Please take several minutes to answer these questions so Dr. Sims can help you get better faster. (**Please circle as many that apply**)

1. How have you taken care of your health in the past?

a. Medications
b. Emergency Room
c. Routine Medical
d. Exercise
e. Nutrition/Diet
f. Holistic Care
g. Vitamins
h. Chiropractic
i. Other (please specify): _____

2. How did the previous method(s) work out for you?

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

3. How have others been affected by your health condition?

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

4. What has been affected by this condition? What is it interfering with?

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self-esteem
f. Sleep
g. Time
h. Finances
i. Freedom

Please list some specific examples of how these things have been affected.

_____
_____
_____

5. Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.)
Give examples _____
_____

What are you most concerned with regarding your problem? _____
_____

How do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific
_____
_____

Would you be willing to commit 100% of yourself to getting this problem corrected, if it can be?
_____

Would you be willing to change your habits, diet, lifestyle, etc. if it were determined that was necessary to help you get well and stay healthy?
_____