Full Life Wellness Center

Patient's Name: ______________________________ **Date:** ____________________

Address: ______________________________ **City:** ____________________

State/Province: ______________________________ **Zip/Postal Code:** ____________________

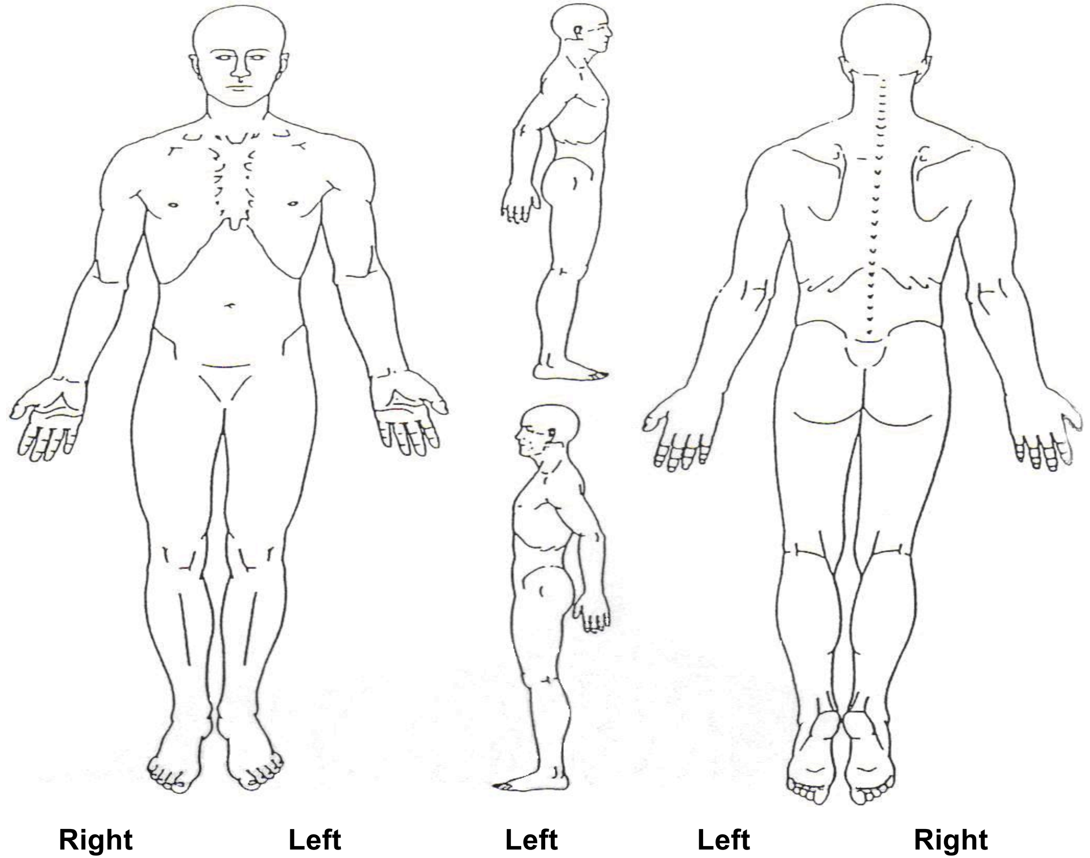
Date of Birth: ____________________ **Age:** __________ **Gender:** __________ **❐ R ❐ L Handed**

Phone #: ______________________________ **Email:** ______________________________

Please mark the area and type of pain on the drawing using the following code:

N – Numbness
P – Pain
T – Tingling
A – Ache
S – Soreness
ST – Stiffness

Please mark all scars using the following: ++++



What are your current complaints? ____

____

____

____

____

____

____

Have you ever been diagnosed with cancer? ❒ Y ❒ N

Date: ____________________ Type: ____________________

Do you have any current diagnoses / diseases / conditions? ❒ Y ❒ N

List diagnoses / diseases / conditions: ____________________

____

Have you had any surgeries? ❒ Y ❒ N

List surgeries and dates: ____________________

____

Have you had any broken bones / fractures? ❒ Y ❒ N

List bones broken / fractures and dates: ____________________

____

Have you had any dental work in the past 2 months? ❒ Y ❒ N

Type of work and dates (give location – ex. rear upper molars): ____________________

Have you had a flu, cold, or respiratory illness in the past month? ❒ Y ❒ N

Do you suffer from any condition other than that which has been listed previously? ❒ Y ❒ N

If yes, what is it? ____________________

I have completed this 2-page form to the best of my ability.

Signature: ____________________ Date: ____________________

Office Use Only: Office: ____________________ Re-Exam: ❒ Y ❒ N
Pt T: __________ F / C Rm T: __________ C