



DR. CHRISTOPHER POWELL, DC
412-243-WELL (9355)
www.WellnessPittsburgh.com

PERSONAL CONTACT INFORMATION

Today's Date: _____ Date of Birth: _____

Last Name: _____ First: _____ Middle Initial: _____ Nickname? _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Preferred daytime number to reach you? H / C / W

Cell Phone: _____ Work Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Whom may we thank for referring you to our office? _____

Emergency Contact: _____ Relationship: _____

Phone numbers: _____

REASON FOR VISIT

Are you seeking wellness care? Y / N

Do you have a chief complaint? Y / N (if not, skip to Wellness Questionnaire)

If so, please list, then answer the following: _____

When did you first notice your symptom/s (date)? _____

What were you doing when the symptom/s first appeared? _____

Is the condition getting progressively worse? Y / N / not sure

Is it related to an injury? Y / N please list: _____

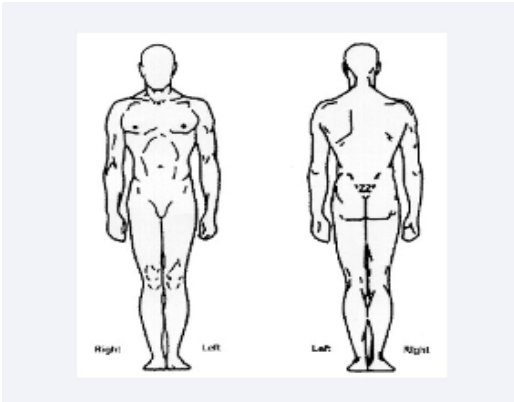
Have you had this or similar conditions in the past? Y / N

Does it interfere with your Work / Sleep / Daily Routine / Enjoyment of Life / Recreation

How does this make you feel (angry, complacent, sad, etc.)? _____



DR. CHRISTOPHER POWELL, DC
412-243-WELL (9355)
www.WellnessPittsburgh.com



Activities or movements that are painful to perform: Sitting / Standing / Walking / Bending / Lying Down

Rate the severity of your pain:

0 1 2 3 4 5 6 7 8 9 10

No pain

Intolerable pain

Type of pain: Sharp / Dull / Throbbing / Numb / Aching / Shooting / Burning / Tingling / Cramps / Stiffness / Swelling / Other _____

Mark an X on the specific pain location:

Would you say the pain is:

- ___ Minimal (annoyance)
- ___ Slight (tolerable)
- ___ Moderate (prevents some activity)
- ___ Marked (precludes any activity)

Pain interval spacing or frequency:

- ___ Intermittent (0 – 25% of the time)
- ___ Occasional (25 – 50% of the time)
- ___ Frequent (50 – 75% of the time)
- ___ Constant (75 – 100% of the time)

How often do you have this pain? _____

How long does the pain usually last? _____

Does the pain intensity change? Y / N

Did you have this condition prior to a trauma or accident? Y / N

To your awareness, is the pain related to other conditions or illness? Y / N

If yes, please explain: _____

Why do you think you haven't been able to adapt to this problem? _____

Are you aware your body is self healing and self regulating? _____

Are you aware of the system of the body that controls this regulation? _____

If there is interference to the nervous system, can you ever be 100% healthy? _____



DR. CHRISTOPHER POWELL, DC
412-243-WELL (9355)
www.WellnessPittsburgh.com

WELLNESS QUESTIONNAIRE

Your care here at Powell Chiropractic is ultimately about wellness care. Granted, many of us have symptoms or issues that need to be dealt with immediately, but eventually, as those become resolved we have the ability to create the life and health picture of our dreams. We are here to discover your goals and priorities to assist you in achieving a wellness status so please help us define what that would like for you.

On a scale of 1 – 10, rate the importance for you to achieve the following:
1 = not important 10 = necessary

Table with 11 rows of wellness goals and a 1-10 scale for each.

List 3 goals you would love to achieve regarding your perfect health and your ideal life. Use your imagination and assume that anything would be possible for you:

- 1.
2.
3.

On this scale of 1 – 10 demonstrate what you would be willing to change, let go of, shift, start, or stop in order to accomplish these goals.

1 2 3 4 5 6 7 8 9 10
Not much Almost anything

Does it feel possible to you that these goals are achievable for you personally? Y / N

Have you ever attempted to accomplish these goals in the past? Y / N

If yes, what happened and what prevented you from maintaining your results?

Would you be willing to investigate any subconscious interference that may be getting in your way? (You wouldn't have to reveal any personal information in order to do so!) Y / N



DR. CHRISTOPHER POWELL, DC
 412-243-WELL (9355)
 www.WellnessPittsburgh.com

Remember: your health is your greatest asset, the more of it you have the healthier you are. We look forward to helping you Discover True Wellness.

“With your commitment and this technology we can make a difference.”

HEALTH HISTORY

Please circle to indicate if you have had any of the following:

| | | | | |
|---------------------|---------------------|----------------------|---------------------|---|
| AIDS/HIV | Diabetes | Measles | Rheumatic Fever | Exercise: None / Moderate / Daily / Heavy |
| Alcoholism | Emphysema | Migraines | Scarlet Fever | Work Activity: |
| Allergy Shots | Epilepsy | Miscarriage | Sexually | ___ Sitting |
| Anemia | Fractures | Mononucleosis | Transmitted Disease | ___ Standing |
| Anorexia | Glaucoma | Multiple Sclerosis | Stroke | ___ Light Labor |
| Appendicitis | Goiter | Mumps | Suicide Attempt | ___ Heavy Labor |
| Arthritis | Gonorrhea | Osteoporosis | Thyroid Problems | Are you pregnant? Y / N EDD: _____ |
| Asthma | Gout | Pacemaker | Tonsillitis | Allergies: _____ |
| Bleeding Disorders | Heart Disease | Parkinson's Disease | Tuberculosis | Medications: _____ |
| Breast Lump | Hernia | Pinched Nerve | Tumors, Growths | Supplements (vitamins, herbs, etc) _____ |
| Bronchitis | Herniated Disk | Pneumonia | Typhoid Fever | _____ |
| Bulimia | Herpes | Polio | Ulcers | _____ |
| Cancer | High Blood Pressure | Prostate Problem | Vaginal Infections | _____ |
| Cataracts | High Cholesterol | Psychiatric Care | Whooping Cough | _____ |
| Chemical Dependency | Kidney Disease | Rheumatoid Arthritis | Other _____ | _____ |
| Chicken Pox | Liver Disease | | | _____ |

| Injuries/Surgeries you have had | Description | Date |
|---------------------------------|-------------|-------|
| Falls _____ | _____ | _____ |
| Broken Bones _____ | _____ | _____ |
| Head Injuries _____ | _____ | _____ |
| Dislocations _____ | _____ | _____ |
| Surgeries _____ | _____ | _____ |

Name and address of other doctor(s) who have treated you: _____

Do you have any concerns you would like to share that haven't been covered? _____

SIGNATURE ON FILE: I certify that all of the above information is correct to the best of my knowledge. I am hereby authorizing Dr.s Christopher and Monique Powell to disclose all pertinent health information to the appropriate parties, always in appliance with HIPAA laws and regulations. I am hereby giving my consent to electronically charge or debit certain accounts for payment for services rendered.

Signature: _____

Date: _____