The Gertonson Institute:
A Creating Wellness
Center

Patient Information

Date: _____

Last Name: _____ First: _____ Middle Initial: _____
Height: _____ Weight: _____
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____ E-Mail: _____
Home Phone: _____ Work Phone: _____
Driver License #: _____ Soc. Sec. #: _____
Date of Birth: _____ Gender: M F Age now: _____
Marital Status: _____ Spouse's Name: _____
Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

Children Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Pets: _____ _____ _____

How did you find out about this office? _____
If it was a friend, whom may I thank? _____

EMERGENCY CONTACT INFORMATION:
Name: _____ Relationship: _____
Phone #: Home: _____ Mobile: _____
Physician Name: _____
Phone #: _____

Patient Signature: _____

Date: _____

Name: _____

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IS THIS A WELLNESS VISIT ☐ NERVOUS SYSTEM EVALUATION ☐
OR DO YOU HAVE A HEALTH PROBLEM?
WHAT IS THE PROBLEM? _____
SINCE THE BODY IS SELF-HEALING AND SELF-REGULATING, WHY DO YOU THINK YOUR BODY ISN'T HEALING THIS PROBLEM AT THIS TIME? _____
_____

ON A SCALE OF 1-10 PLEASE RATE YOUR LEVEL OF:

1. HAPPINESS	POOR	1	2	3	4	5	6	7	8	9	10	EXCELLENT
2. NUTRITION	POOR	1	2	3	4	5	6	7	8	9	10	EXCELLENT
3. EXERCISE	POOR	1	2	3	4	5	6	7	8	9	10	EXCELLENT
4. REST	POOR	1	2	3	4	5	6	7	8	9	10	EXCELLENT
5. STRESS	POOR	1	2	3	4	5	6	7	8	9	10	EXCELLENT
6. OVERALL HEALTH	POOR	1	2	3	4	5	6	7	8	9	10	EXCELLENT
7. FAMILY'S HEALTH	POOR	1	2	3	4	5	6	7	8	9	10	EXCELLENT

HOW SATISFIED ARE YOU WITH YOUR CURRENT LEVEL OF HEALTH?

NOT VERY 1 2 3 4 5 6 7 8 9 10 VERY SATISFIED

HOW DO YOU TAKE CARE OF YOUR:

TEETH _____ EYES: _____
HEART _____ SKIN: _____
SPINE _____ NERVOUS SYSTEM: _____

HOW IMPORTANT IS IT FOR YOU TO BE HEALTHY?

NOT VERY 1 2 3 4 5 6 7 8 9 10 VERY SATISFIED

HOW COMMITED ARE YOU TO CHANGING YOUR SITUATION?

NOT VERY 1 2 3 4 5 6 7 8 9 10 VERY SATISFIED

WHAT ARE YOUR HEALTH GOALS? _____
HOW CAN WE HELP YOU ACHIEVE YOUR HEALTH GOALS? _____
_____

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DAILY NUTRITION

PLEASE LIST YOUR TYPICAL DAY'S MEALS:

BREAKFAST: _____

LUNCH: _____

DINNER: _____

ON AVERAGE, HOW MANY SERVINGS OF FRUITS AND VEGETABLES DO YOU EAT DAILY? _____

HOW MANY GLASSES OF WATER DO YOU DRINK PER DAY? _____

HOW MANY HOURS OF UNITERRUPTED SLEEP DO YOU TYPICALLY GET PER NIGHT? _____

DO YOU USUALLY FEEL WELL RESTED WHEN YOU WAKE UP? _____

ARE YOU SATISFIED WITH YOUR WEIGHT? **Y** **N**

IF NOT, DO YOU WISH TO LOSE/GAIN WEIGHT? **Y** **N**

HOW MANY SICK CARE VISITS TO THE MEDICAL DOCTOR DID YOU MAKE LAST YEAR? _____

HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE? **Y** **N** FOR WELLNESS CARE? **Y** **N**

HAVE YOU EVER SEEN AN ACUPUNCTURIST? **Y** **N** A NATUROPATHIC DOCTOR? **Y** **N**

HAVE YOU EVER HAD MASSAGE? **Y** **N** REIKI? **Y** **N**

HAVE YOU EVER DONE YOGA? **Y** **N** PILATES? Y N TAI CHI/QI GONG? **Y** **N**

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DO YOU:

SMOKE: **Y** **N** DRINK COFFEE? **Y** **N** HOW MUCH? _____

DRINK ALCOHOL? **Y** **N** HOW MUCH/OFTEN? _____

DRINK BOTTLED/FILTERED WATER? **Y** **N**
TAKE VITAMINS/SUPPLEMENTS? **Y** **N** IF YES, PLEASE LIST

_____

_____

TAKE ANY PRESCRIPTION MEDICATIONS: **Y** **N** IF YES, PLEASE LIST

_____

WORKOUT/EXERCISE REGULARLY? **Y** **N** IF YES, WHAT KIND AND HOW OFTEN?

_____

_____

BUY ORGANIC FOOD? **Y** **N**
REGULARLY PRACTICE MEDICATION OR PRAYER? **Y** **N**

HAVE ANY HOBBIES/INTERESTS? **Y** **N** PLEASE LIST

_____

PARTICIPATE IN ANY SPORTS/RECREATIONAL ACTIVITIES? **Y** **N** PLEASE LIST

_____

BELONG TO ANY CLUBS OR ORGANIZATIONS? **Y** **N** PLEASE LIST

_____

SIT AT WORK/SCHOOL? **Y** **N** HOW MANY HOURS? _____

Mark all that apply (C = current P = past)

- ☐ Jaw Pain
- ☐ Lung Problems
- ☐ Cold Extremities
- ☐ Vision Problems
- ☐ Allergies
- ☐ Excessive Appetite
- ☐ Nervousness
- ☐ Depression
- ☐ Excessive Thirst
- ☐ High Cholesterol
- ☐ Psychiatric Problems
- ☐ Kidney Problems
- ☐ Artificial Bones/Joints
- ☐ Cardiovascular Disease
- ☐ Congestive Heart Failure
- ☐ Bladder Trouble
- ☐ Irritable Bowel
- ☐ Liver Problems/Hepatitis
- ☐ Tingling
- ☐ Fatigue
- ☐ Ear Pain
- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Cancer
- ☐ Sinus Problems
- ☐ Fibromyalgia
- ☐ Skin Problems: Ezcema,Psoriasis or Rashes
- ☐ Eating Disorder
- ☐ Frequent Neck Pain
- ☐ High/Low Blood Pressure
- ☐ Severe/Frequent Headaches
- ☐ Fainting/Seizures/Epilepsy
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Lower Back Pain
- ☐ Heart Surg./Pacemaker
- ☐ Shingles
- ☐ Heart Murmur
- ☐ Arthritis
- ☐ Asthma
- ☐ Difficulty Breathing
- ☐ Ulcers/Colitis
- ☐ Other