

Application For Admission

Today's Date _____
Name _____ Age _____ Birthday _____ Sex M F
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell
Phone _____
Best Place To Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? Yes No
Employer _____ Occupation _____ Length of
Employ _____
Marital Status S M W D Number of children _____ Spouses Name _____
SS# _____

I (signature) _____ consent to allow Dr. Wheelwright to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for treatment and also to determine if he is willing to accept my case.

How Did You Hear About Dr. Wheelwright? _____

What Is Your Main Problem(s)/Symptom(s) Prompting Your Request For A Consultation With The Doctor?

Would You Consider This Problem(circle one)... MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitations)
SEVERE (Causing Significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

1. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and in your own opinion what do you think the real problem is?

2. What are you hoping happens today as a result of your consultation with the Doctor?

3. When was the first time you had this symptom, please describe?

4. Have you ever been given an official diagnosis of your problem?

5. What diagnostic tool(s) were used to achieve that diagnosis?

6. Since your symptoms began what three things has it caused you to miss the most?

7. What kinds of treatments have you received for this condition?

Prescriptions or Drug Therapy _____
Nutritional Therapy _____
Alternative or Holistic Therapy _____
Surgery _____

8. When did you receive these treatments and for how long?

9. Did any of these treatments work? If so which one(s)? For how long?

10. Is there anything you have done on your own, outside of medical advise that improved your condition?

11. What activities or situations are guaranteed to make it worse?

12. Are your symptoms worse in the morning or are they worse as the day progresses?

13. If you cannot find a solution to this problem what do you think will happen to you?

14. Describe what will be different in your life if you can get better.

15. What has the problem cost you? (time, money, happiness, freedom, sleep, promotions, etc.)

16. How have others been affected by your condition?

17. On a scale from 1-5 with 5 being very healthy, how healthy do you rate your diet? _____

18. What type of foods do you generally eat?

List In Order Of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above.

1. _____ How Long Have You Had This? _____
2. _____ How Long Have You Had This? _____
3. _____ How Long Have You Had This? _____
4. _____ How Long Have You Had This? _____

In Reference To Your MAIN PROBLEM How Often Are You Aware of This Problem? (circle one)

- Occasionally (25% of the time)
- Intermittently (50% of the time)
- Frequently (75% of the time)
- Constant (90-100% of the time)

Due To Your Main Problem.....

Have You Lost Any Time From Work? Yes No
How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Chores/Tasks At Home? Yes No
How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Family? Yes No
How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Liesure Activities? (Hobbies, Travel, Sports, etc...)
How Much Time and What Tasks Have Been Limited?

List ANY surgeries that you have had and the corresponding dates.

Have you had ANY of the following in the last 12 months or currently.
(Mark C for Current. X for in last 12 mos.)

GENERAL

Chills ___ Convulsions ___ Dizziness ___ Fainting ___ Fatigue ___ Fever ___ Headache ___
Loss of Sleep ___ Allergy ___ (to what _____) Loss of Weight ___ Nervousness ___
Wheezing ___ Bronchitis ___
Numbness in BOTH hands AND feet ___

CARDIOVASCULAR

High Blood Pressure ___ Low Blood Pressure ___ Pain over heart ___ Poor Circulation ___ Rapid
Heartbeat ___ Previous Heart Problem ___ (Describe _____) Slow Heartbeat
___ Stroke ___ TIA ___ Swollen Ankles ___ Varicose Veins ___ Aortic Aneurysm ___ Bruise
Easily ___

DISEASES/CONDITIONS

Appendicitis ___ Anemia ___ Arthritis ___ Alcoholism ___ Abdominal Surgery ___ Bleeding
Disorder ___ Blood Clot(s) ___ Breathing Difficulty ___ Cancer ___ Cholesterol High ___ Colon
Problems ___ Diabetes ___ Depression ___ Epilepsy ___ Eczema ___ Eating Disorder ___
Glaucoma ___ HIV + ___ Heart Disease ___ Hernia ___ Headaches ___ Influenza ___ Kidney
Disease ___ Liver Disease ___ Low back Pain ___ Mental Illness ___ Measles ___ Mumps ___
Pleurisy ___ Pneumonia ___ Polio ___ Prostate Problems ___ Hyperthyroid ___ Hypothyroid ___
Rectal Surgery ___

EARS/EYES/NOSE/THROAT

Asthma ___ Crossed Eyes ___ Double Vision ___ Blurred Vision ___ Difficulty Swallowing
___ Deafness ___ Hearing Loss ___ Ear Pain ___ Thyroid Problem ___ Nose Bleeds ___ Sinus
Problems ___ Sore Throats ___

GASTRO-INTESTINAL

Gas ___ Colon Trouble ___ Constipation ___ Diarrhea ___ Gallbladder Trouble ___ Hemorrhoids
___ Liver Trouble ___ Nausea ___ Stomach Ache ___ Poor Appetite ___ Poor Digestion ___
Vomiting ___ Vomiting Blood ___ Rectal Bleeding ___ Bloating ___

GENITO-URINARY

Blood in Urine ___ Frequent Urination ___ Inability to control urine ___ Kidney Infection ___ Painful
Urination ___ Prostate Trouble ___ Painful Urination ___

FOR MEN ONLY

Lump in testicles ___ Penis discharge ___

FOR WOMEN ONLY

Menstrual Cramps ___ Excessive menstrual flow ___ Hot Flashes ___ Irregular Cycle ___ Painful
periods ___ Birth Control Pills ___ Abnormal Pap Smear ___

MUSCLE/JOINT/BONE

Backache ___ Foot Trouble ___ Pain Between Shoulders ___ Painful Tailbone ___ Stiff Neck
___ Spinal Curvature ___ Swollen Joints ___

NEUROLOGIC

Seizures ___ Dizziness ___ Hand Trembling ___ Weakness ___ Difficulty with speech ___ Loss of
memory ___ Loss of coordination ___

RESPIRATORY

Chest Pain ___ Chronic Cough ___ Difficulty Breathing ___ Coughing/Spitting Blood ___