Welcome to Elevation Now Wellness Center

Our mission at Elevation Now Wellness Center is to help you achieve all your health goals and needs. Whether your main reason for seeing us to get out of pain, increase your energy, lose weight, or simply take your health to the next level, we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step in the process is to establish your current state of health and the overall function of your body. In order for us to assess this and understand the root cause of your symptoms, we will take you through a series of non-invasive examinations on your initial visit. This includes a full case history, nerve and muscle tests, postural analysis, functional movement assessment, bioimpedance analysis, and blood pressure tests.

There are a few simple steps for you to follow prior to your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine or food for 4 hours
- Consume 2-4 glasses of water within 2 hours

On the day of your visit, we ask that you wear comfortable clothing you can easily move in. We will take a postural photo of you, so please avoid multiple layers or bulky clothing. Full tights and pantyhose will need to be removed.

At your initial visit, please bring all completed paperwork (5 pages total) and any recent blood work with you so we may refer to these during our case history.

Your initial assessment will take between 45-60 minutes. Please allow sufficient time for your appointment. If you have time constraints, contact our front desk prior to your visit.

PLEASE NOTE:
We have a 24-hour cancellation policy where the agreed upon initial exam fee will be charged if prior notice has not been given. If you are running late please contact the front desk at 970-263-9100. Late arrivals do run the risk of requiring a rescheduled appointment.

GENERAL INFORMATION

Please full out the forms *completely* and *accurately* to the best of your ability so we can quickly get you on the road to health.

Today's Date: ________________________

Name: ____
Last First Middle Initial

Street Address: ____ City: ________________ State: ________ Zip Code: ________

Email: ____

Cell Phone Number: _________________________________ Home Phone Number: _____________________________

Preferred method of communication (select one): Email _______ Text _______ Phone: _______

Sex: Male _____ Female _____ Date of Birth: ___________________________ Age: _____

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Partnered ______

Spouse's Name: _______________________________ Phone: __________________

Occupation: ____

EMERGENCY CONTACT

Name of Emergency Contact: ____

Relationship: ____ Phone: ____

ACCIDENT INFORMATION

Is your condition due to an accident? Yes _____ No _____ Date of Accident: _______________________________________

Type of Accident: Auto _____ Work _____ Home _____ Other (please describe) __________________________________

YOUR VISIT

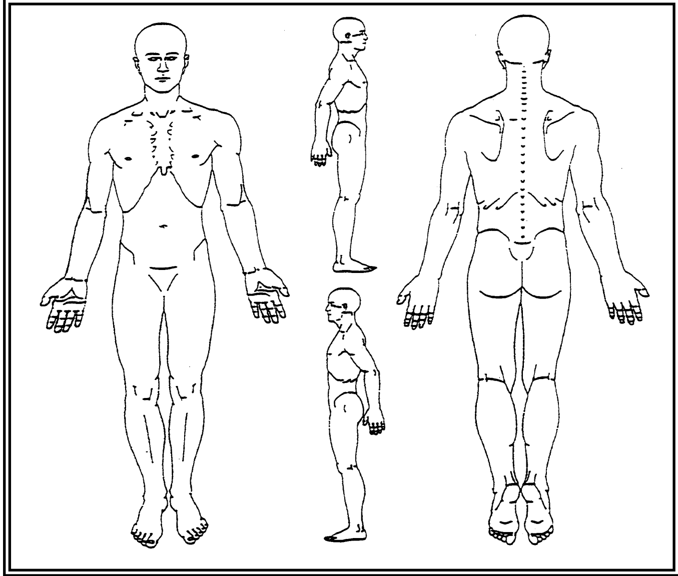
We appreciate you choosing our office. Is there anyone we can thank for referring you? _____________________________________

Please indicate the main reason you are seeing us today: ____

____

ELEVATION NOW

YOUR VISIT	NAME:	DATE:



If you are seeing us for a pain-related issue, USE THE SYMBOLS on the image to the right to show the type of pain you feel in each location.

X X X X X X X X	DULL / ACHY
/ / / / / / / / / /	SHARP / STABBING
o o o o o o o o	NUMBNESS / TINGLING
s s s s s s s s s s	STIFF/TIGHT
- - - - - - - - - - - -	BURNING

Using the pain scale to the right, CIRCLE the pain level you experience when your problem is at its very worst.

0 = **No Pain**. No Discomfort
1 = **Minimal Discomfort**. Minor stiffness or tightness.
2 = **Discomfort**. Stiff, tight, sore. Muscle fatigue.
3 = **Minimal Pain**. More than just sore. Uncomfortable.
4 = **Mild Pain**. Noticeable pain but tolerable.
5 = **Moderate Pain**. Aggravating. Still allows movement.
6 = **Strong Pain**. Quite aggravating. Movement slightly limited.
7 = **Very Strong Pain**. Very aggravating. Movement definitely limited.
8 = **Very, Very Strong Pain**. Extremely aggravating. Movement very limited.
9 = **Severe Pain**. Brings tears. Almost impossible to move.
10 = **Excruciating Pain**. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? Yes _____ No _____ Is there any numbness or tingling? Yes _____ No _____

How often do you experience your problem? (Please indicate for each of the body locations, if applicable)

Constant (75-100% of the time): ____________________________ Frequent (50-75% of the time): ____________________________
Occasional (25-50% of the time): ___________________________ Intermittent (0-25% of the time): ___________________________

List any MDs or Chiropractors you've already seen for this problem: ____

____

What tests have you already had for this problem? X-rays _____ MRI _____ Myelogram _____ EMG / NCV _____ None _____
Other (please describe) ____

What makes your problem **worse**? Sitting _____ Standing _____ Changing Position _____ Walking _____ Bending _____
Lifting _____ Twisting _____ Reaching _____ Driving _____ Sleeping _____ Sneeze / Cough _____ Computer Work _____
Telephone _____ Going from Sit to Stand _____ Other (please describe) ____

MEDICAL HISTORY	**NAME:**	**DATE:**

Please list any significant conditions you've been diagnosed with or have been treated for over the course of your life: ____________

____

____

Please list any surgeries you have had over the course of your life: ____

____

Are you allergic to any medications? Yes _______ No _______ If yes, please list: ____

List any medications, herbs, or supplements you are taking and the reason for their use: _____________________________________

____

____

____

FAMILY HISTORY

Mother: Living _______ Deceased _______ List any medical problems: ____

Father: Living _______ Deceased _______ List any medical problems: ____

Mark any problems common to your family: Cancer _____ Diabetes _____ Heart disease _____ High blood pressure _____

Stroke _____ Arthritis _____ Scoliosis _____ Thyroid disease _____ Osteoporosis _____ Other (describe) _____________

SOCIAL HISTORY

Do you have any children? Yes _______ No _______ If yes, how many? ____

Do you drink alcohol? Yes _______ No _______ If yes, how much and how often? _______________________________________

Do you smoke? Yes _______ No _______ If yes, how much, how often and how long? ___________________________________

Are you currently employed? Yes _______ No _______

Who is your current employer? ______________________________ How long have you been at this job? ______________________

What do you do most of the day in your job postures, positions, and repetitive movements? __________________________________

____

On a scale of 0-10 (0 = Worst and 10 = Best) rate how well you think you are doing with the following:

Exercise _______ Sleep_______ Diet _______ Stress Level _______ Water Intake _______ Energy Level _______

REVIEW OF SYSTEMS	NAME:	DATE:

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days:

0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

GRAND TOTAL:

Head: _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia	**Energy / Activity:** _____ Fatigue / Sluggishness _____ Apathy / Lethargy _____ Hyperactivity _____ Restlessness	**Lungs:** _____ Chest Congestion _____ Asthma, Bronchitis _____ Shortness of Breath _____ Difficulty Breathing
Eyes: _____ Watery or Itchy Eyes _____ Swollen, Red or Sticky Eyelids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (not including near or far sightedness)	**Weight:** _____ Binge Eating / Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight	**Heart:** _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain
Ears: _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage from Ear _____ Ringing in Ears, Hearing Loss	**Emotions:** _____ Mood Swings _____ Anxiety / Fear / Nervousness _____ Anger / Irritability / Aggressiveness _____ Depression	**Digestive Tract:** _____ Nausea, Vomiting _____ Diarrhea _____ Constipation _____ Bloated Feeling _____ Belching, Passing Gas _____ Heartburn _____ Intestinal / Stomach Pain
Nose: _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus Formation	**Mind:** _____ Poor Memory _____ Confusion, Poor Comprehension _____ Poor Concentration _____ Poor Physical Condition _____ Difficulty Making Decisions _____ Stuttering or Stammering _____ Slurred Speech	**Mouth and Throat:** _____ Chronic Coughing _____ Frequent Need to Clear Throat _____ Sore Throat, Hoarseness _____ Swollen or Discolored Tongue _____ Canker Sores
Skin: _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating	**Joints / Muscles:** _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limited Movement _____ Pain or Aches in Muscles _____ Weakness or Fatigued Muscles	**Other:** _____ Frequent Illness _____ Frequent or Urgent Urination _____ Genital Itch or Discharge

Elevation Now Wellness Center

Patient Authorization Form

Patient Authorization for:

* Contact regarding appointment reminders, scheduling related and account balance matters, birthday, greetings, chiropractic care, related health services and/or related health products

* Sign-In Sheet

* Testimonials / Success Stories

It is our desire for the staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, birthday greetings or other appointment related or account balance issues and also to advise you about health-related meetings, workshops and products. We also display your name on our sign-in sheet and any testimonials/success stories we receive from you.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose to not authorize this information use, your decision will have no adverse effect on your care from Dr. Nick Sechrist or on your relationship with our staff.

Your signature indicates authorizations of this activity.

___________________________	____________________________	________________
Name (Printed)	Signature	Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system.