NEW PATIENT FORMS PRINT:
24 STANDARD LETTER SIZE PAGES

WM WELLNESS MEDICINE

an infinitely better idea.

William M. Maykel D.C., D.I.B.A.K.
Doctor of Chiropractic (D.C.)
Diplomate of the International Board of
Applied Kinesiology (D.I.B.A.K.)
Specializing in Wellness Medicine

Dear,

Welcome to our total wellness clinic that specializes in Professional Applied Kinesiology and Functional Medicine. You have taken the first step on the road to improving your health and quality of life. We know that you have specific health care goals. We use our expertise with a wide range of treatments to help you meet your goals.

Our offices use soft laser and frequency specific micro currents to promote rapid healing. Our detoxification center has a Far Infrared Sauna and EB-Pro Energy Balancer, both of which improve your immune system and increase your energy level. Bio-Cellular Analysis for analyzing your blood, urine and saliva is available at our Auburn office.

Professional Applied Kinesiology is a personalized approach to healthcare that integrates the best of physical medicine, clinical nutrition, and environmental medicine. To implement this approach, our clinics strive to give you the best broad scope education. We provide cutting edge information for life style management, including clinical nutrition, diet, exercise, structural alignment, and Whole body/mind balance.

_____ , at _____ .

We look forward to meeting and working with you at your first appointment which is scheduled for

Your first appointment will last 60–90 minutes. Due to the length of this appointment, please contact us 24 hours in advance if you need to reschedule this appointment. If you are cancelling a Monday appointment, you must contact us no later than 1:00 p.m. on Thursday. A full charge will be applied to your credit card for missed appointments.

Please remember to complete the forms in this New Patient Information Packet and bring them to your appointment along with the results of any medical tests and diagnostic imaging reports, any prescription medicines you are taking, and all nutritional supplements. Finally, we look forward to helping your create and maintain a higher level of health.

Sincerely,
William M. Maykel, D.C., D.I.B.A.K.

New Patient Registration Date: _____

Patient Information	Name:		
	Mailing Address		
	Street:		City/Town:
	State:	Zip Code:	Email Address:
	Home Phone:	Work Phone:	Mobile Phone:
	Date of Birth:	Age:	Sex: ☐ Male ☐ Female
	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
	Primary Care Physician:		Phone:
	Primary Care Physician Address:		
	Occupation:	Employer Name:	
	How did you hear about us?		
Emergency Information	Name of Contact:	Phone Number:	Relationship to Patient:
List of Prescription Medications, Vitamins and Nutritional Supplements	Name:	Dosage:	Length of Use:
	Name:	Dosage:	Length of Use:
	Name:	Dosage:	Length of Use:
	Name:	Dosage:	Length of Use:
	Name:	Dosage:	Length of Use:
	Attach a separate sheet if you need more space.		

Your first appointment is scheduled for: _____

To increase the value of your first visit, **please** bring the following when you come in for this appointment:

☐ Completed forms in your New Patient Information Packet.

☐ Copies of all recent Lab work.

☐ Reports, including MRI results, X-rays, Ultrasounds, and/or CT Scans.

To rule out sensitivity or adverse reactions using muscle testing, bring all:

☐ Prescription Medications, and

☐ Vitamins and Nutritional Supplements.

List your chief complaints or health concerns in order of your priority to resolve them

1. Location Complaint ______________________________

2. Rate the intensity 0–10 and circle the correct description of the problem.

0 2 3 4 5 6 7 8 9 10

Ache Burning Stabbing Numbness Pins & Needles Other

3. How long have you had it? ______________________________

4. Circle what applies: Constant or Intermittent

Anything that makes it better or worse ______________________________

---

1. Location Complaint ______________________________

2. Rate the intensity 0–10 and circle the correct description of the problem.

0 2 3 4 5 6 7 8 9 10

Ache Burning Stabbing Numbness Pins & Needles Other

3. How long have you had it? ______________________________

4. Circle what applies: Constant or Intermittent

Anything that makes it better or worse ______________________________

---

1. Location Complaint ______________________________

2. Rate the intensity 0–10 and circle the correct description of the problem.

0 2 3 4 5 6 7 8 9 10

Ache Burning Stabbing Numbness Pins & Needles Other

3. How long have you had it? ______________________________

4. Circle what applies: Constant or Intermittent

Anything that makes it better or worse ______________________________

Continued on next page

List your chief complaints or health concerns in order of your priority to resolve them, Continued

1. Location Complaint _____

2. Rate the intensity 0–10 and circle the correct description of the problem.

0 2 3 4 5 6 7 8 9 10

Ache Burning Stabbing Numbness Pins & Needles Other

3. How long have you had it? _____

4. Circle what applies: Constant or Intermittent

Anything that makes it better or worse _____

List any medications, vitamins or supplements, the dosage and how long you've been taking them.

Name _____dosage_____ how long_____

Name _____dosage_____ how long_____

Name _____dosage_____ how long_____

Name _____dosage_____ how long_____

Name _____dosage_____ how long_____

Name _____dosage_____ how long_____

General Health Factors, Continued

Patient Name:_____ **Date:**_____

Sleep Habits

What is your average amount of sleep per night? _____ Hours

What is the average number of times you get up to urinate? _____

Indicate the level of difficulty you have with each of the sleep habits in the table below.

Sleep Habits	Falling Asleep	Staying Asleep	Awaken Refreshed	Awaken Frequently
Sometimes				
Always				
Never				

Your Mattress

What brand is your mattress? _____

Is it a ____ traditional mattress ____ waterbed, or ____ a foam mattress?

Is it ____ firm, or ____ soft?

Do you use an electric blanket? ____ Yes ____ No

How would you describe your mood?

____ Upbeat ____ Anxious ____ Depressed ____ Steady ____ Up and Down

Indicate how long you have felt this way? ____ Months ____Years

Memory Issues

Indicate the state of your short and long term memory in the table below.

Note: If you choose fair or poor, indicate how long it has been this way.

Memory	Excellent	Good	Fair	How Long?		Poor	How Long?	
				Months	Years		Months	Years
Short Term								
Long Term								

Continued on next page

General Health Factors, Continued

Job Stress

Indicate your level of job stress. ____ Mild ____ Moderate ____ Severe

How long have you been under this stress? ____ Months ____ Years

Overall Energy

Indicate your overall level of energy. ____ Excellent ____ Good ____ Fair ____ Poor

How long have you felt this way? ____ Months ____ Years

Condition

Muscles/ Joints

Indicate the condition of your muscles and joints.

____ Relaxed/Limber ____ Tight/Stiff ____ Spasms/Unstable

Use of Massage Therapy

Do you use massage therapy for your muscles/joints? ____ Yes ____ No

If yes, what type?

____ Swedish ____ Deep Tissue ____ Shiatsu _____ Other

How often do you use massage therapy?

_____ times per Week _____ times per Month

Continued on next page

General Health Factors, Continued

Exercise

Resistance training is the use of weights to gain strength. Cardiovascular training refers to exercise that raises your heart rate.

If you currently exercise, indicate the type and frequency in the table below.

Type of Exercise	Times Per Week	Time Per Workout	
		Minutes	Hours
Resistance Training			
Core			
Free Weights			
Machines			
Cardiovascular Training			
Walking			
Running			
Rowing			
Swimming			
Mountain Bike			
Road Bike			
Stationary Bike			
Treadmill			
Stair Master			
Elliptical			
Aerobics			
Other Training			
Yoga			
Pilates			
Spinning			

Resistance training is the use of weights to gain strength. Cardiovascular training refers to exercise that raises your heart rate.

If you currently exercise, indicate the type and frequency in the table below.

Do you participate in any other type of exercise? ____ Yes ____ No

If yes, please describe:

_____

Illnesses

Childhood Illnesses

Indicate if you had any of the following childhood illnesses.

Illness	Yes	No
Measles		
Mumps		
Chicken Pox		

Have you had any other childhood illnesses? ____ Yes ____ No

If yes, please describe:

Recurring Infections

Indicate if you have any of the following recurring illnesses.

Illness	Yes	No
Middle Ear Infections		
Asthma		
Bronchitis		

Recurring Illnesses

Have you had any other recurring illnesses? ____ Yes ____ No

If yes, please describe:

Do you have recurrent infections anywhere in your body, such as sinus, skin, lungs, urinary tract? ____ Yes ____ No

If yes, please describe:

Do you get more than 2 colds a year? ____ Yes ____ No

If yes, please describe:

Continued on next page

Illnesses, Continued

Allergies

Do you suffer from seasonal allergies? ____ Yes ____ No

Do you suffer from hay fever? ____ Yes ____ No

Do you suffer from fixed allergies? ____ Yes ____ No

If yes, please describe:

Have you ever been treated for the following illnesses?

Other Illnesses

Illness	Yes	No	If Yes, Age	Please Describe
Blood Sugar Problems				
Cancer				
Heart Disease				
Hepatitis				
Mononucleosis				
Pneumonia				

Have you had any other illnesses? ____ Yes ____ No

If yes, please describe:

Surgeries

Indicate if you have had any of the following surgeries.

General Surgeries

Procedure	Yes	No
Appendectomy		
C-Section		
Gall Bladder Removal		
Tonsillectomy		

Have you had any other surgeries? ____ Yes ____ No

If yes, please describe:

_____

Previous Trauma

Do you have any long bone fractures? ____ Yes ____ No

If yes, please describe below.

Bone Fractures

Bone Affected	Age	How it Happened

Motor Vehicle Accidents

Have you ever been in a motor vehicle accident? ____ Yes ____ No

If yes, please describe below the accident, even if you were ***not*** injured.

Type of Accident	✔	Driver Restrained	Passenger Restrained	Age	Brief Description
Head-On					
Rear Ended					
Rolled Over					
Other					

Continued on next page

Previous Trauma, Continued

Have you had any accidents that caused a loss of consciousness? _____ Yes _____ No

If yes, please describe below.

Closed Head Injuries

Type of Accident	Age	Brief Description

Other Significant Trauma

Please describe any other significant physical or emotional trauma/adverse health conditions that you may have experienced.

Examples:

Sports injuries, loss of a loved one.

Type of Trauma/Adverse Health Condition	Age	Brief Description

Female Issues

Menstrual Cycle

Indicate the age of your first menstrual cycle. _____ years old

How many days does your cycle last? _____ No. Days

How many days between cycles? ____ 28 days ____ 28–32 days

Is the timing of your cycle regular or ____ Regular ____ Irregular

Irregular?

Please describe your cycle, such as heavy flow, light flow, spotty, crampy.

Premenstrual Syndrome

Do you suffer from premenstrual syndrome (PMS)? ____ Yes ____ No

If yes, is your PMS ____ Mild ____ Moderate ____ Severe

Please indicate if you experience any of the following symptoms during PMS, placing a checkmark for the appropriate degree.

Symptom	Mild	Moderate	Severe	Number of Days Prior to Cycle
Moodiness				
Back Pain				
Abdominal Pain				
Bloating				
Breast Soreness				
Other Describe				

Pelvic Exams

Do you have annual pelvic exams and Pap tests? ____ Yes ____ No

Indicate if your Pap tests are ____ Normal ____ Abnormal.

Continued on next page

Female Issues, Continued

Breast Exams

How often do you have breast exams?

Frequency of Breast Exams _____

Do you perform self-exams on a regular basis? ____ Yes ____ No

Indicate the number of times you have had any of these diagnostic tests:

____ Mammography ____ Ultrasound ____ Thermography ____ MRI

Indicate if your breast tissue is ____ Normal ____ Fibrocystic

Children

Complete the following.

Child's First Name	Current Age	Normal Vaginal Delivery	C-Section

Menopause

What was the date of your last period? Date _____

Do you use hormone replacement therapy? ____ Yes ____ No

If yes, indicate the type of therapy, and how long _____

Type _____

Bone Density Testing

Have you ever had a bone density text? ____ Yes ____ No

If yes, indicate the date of your last test. Date _____

Indicate if the result was ____ Normal ____ Osteopenia ____ Osteoporosis

Was medication prescribed? ____ Yes ____ No

If yes, indicate the type of medication. _____

How long _____

Male Issues

Urination Problems

Do you have trouble starting/stopping urination? ____ Yes ____ No

If yes, indicate how long this has been going on. _____

Do you suffer from lack of bladder control? ____ Yes ____ No

If yes, indicate how long this has been going on.

_____

_____

Prostate Problems

Do you have prostate problems? ____ Yes ____ No

If yes, please describe.

_____

_____

Maintaining Erections

Do you have trouble achieving/maintaining an erection? ____ Yes ____ No

If yes, indicate if the problem is ____ Mild ____ Moderate ____ Severe

How long have you had this problem? ____ Months ____ Years

Digestion and Nutrition

Digestive Symptoms

How many times a day do you have bowel movements? _____ Times

Are your stools ____ loose, or ____ hard?

What color are your stools? ____ normal ____ light ____ dark

Do your stools ____ sink, or ____ float?

Do you suffer from constipation? ____ Yes ____ No

Indicate any digestive symptoms that you experience in the table below.

Symptom	Occurrence	How Long?		Food or Medication Causing the Symptom
		Weeks	Months	
Bloating	____ Less than one hour after eating.			
	____ More than one hour after eating			
Abdominal Pain or Cramping	____ After eating			
	____ Other. Describe			
Heartburn	____ After eating.			
	____ After taking medication.			

Daily Meals

How many meals do you have each day? ____ 1 ____ 2 ____ 3 ____ Other

Describe *Other*.

List the foods that you have at each meal on an average day.

Breakfast	Lunch	Dinner

Continued on next page

Digestion and Nutrition, Continued

Indicate any of the habits that impact your nutritional health in the table below.

Impacts on Health

Habit	Description
Eat Fast Food	Describe what you eat: How often? _____
Junk Food	Describe the junk food: How often? _____
Fried Food	Describe the fried food: How often? _____
Miss Meals	Which meal? How often? _____
Eat Organic Food	____ Fruits ____ Vegetables ____ Beef ____ Chicken % of the time you eat organic food _____
Drink Caffeinated Beverages	____ Coffee ____ Fancy Coffee Tea ____Cocoa ____ Energy Drinks
Drink Soda	____ Regular ____ Diet
Drink Alcohol	____ Hard Liquor _____ Times Per Day _____ Times Per Week ____ Wine/Beer _____Times Per Day _____ Times Per Week
Drink Water	_____ Number of 8 ounce glasses per day ____ Tap ____ Bottled ____ Spring ____ Distilled ____ Filtered
Smoke Cigarettes	____ Currently _____ No. Years _____ Packs per Day ____ In the Past _____ No. Years _____ Packs per Day

Continued on next page

Digestion and Nutrition, Continued

Miscellaneous Factors

Do you use a microwave oven? ____ Yes ____ No

Do you use fluoridated toothpaste? ____ Yes ____ No

Do you use a Bluetooth ear piece with your cell phone? ____ Yes ____ No

Do you use a car seat heater? ____ Yes ____ No

Do you routinely spend time in areas with WiFi ____ Yes ____ No

Do you get an annual flu shot? ____ Yes ____ No

Do you know what a GMO is? ____ Yes ____ No

Medical Symptoms Questionnaire

Patient Name:_____ **Date:**_____

This is a list of common medical symptoms. Place a check mark (✔) in the box that best describes any symptoms you have experienced in the last thirty days. Skip any symptom you have not had.

Part of Body	Symptom	Occasionally/ Mild	Occasionally/ Severe	Frequently/ Severe	Frequently/ Mild
Head	Dizziness				
	Faintness				
	Headache				
	Insomnia				
Eyes	Bags/dark circles under eyes				
	Blurred/tunnel vision				
	Eyelids swollen, red/sticky				
	Watery/Itchy				
Ears	Ear Drainage				
	Earaches				
	Itchy Ears				
	Ringing in Ears/Hearing Loss				
Nose	Excessive mucus				
	Hay fever				
	Sinus problems				
	Sneezing				
	Stuffy nose				
Mouth/ Throat	Canker sores				
	Chronic coughing				
	Gagging/frequent clearing of throat				
	Sore, hoarseness, loss of voice				
	Swollen, discolored Tongue/gums/lips				
Lungs	Chest Pain				
	Irregular/skipped heartbeat				
	Rapid heartbeat				
Heart	Asthma, bronchitis				
	Chest congestion				
	Difficulty breathing				
	Shortness of breath				
Leave this row blank					

Continued on next page

Medical Symptoms Questionnaire, Continued

Part of Body	Symptom	Occasionally/ Mild	Occasionally/ Severe	Frequently/ Severe	Frequently/ Mild
Physical Symptoms, Continued					
Digestive Tract	Belching, passing gas				
	Bloated feeling				
	Constipation				
	Diarrhea				
	Heartburn				
	Intestinal/stomach pain				
	Nausea/vomiting				
Joints/Muscles	Arthritis				
	Feeling weak/tired				
	Pain/aches in joint				
	Pain/aches in muscles				
	Stiff/limited movement				
Skin	Acne				
	Excessive sweating				
	Flushing/hot flashes				
	Hair loss				
	Hives/rashes/dry skin				
	Hives/rashes/dry skin				
General	Frequent Illness				
	Frequent Urination				
	Genital itch! discharge				
Psychological Symptoms					
Energy/ Activity	Apathy/lethargy				
	Fatigue/sluggishness				
	Hyperactivity				
	Restlessness				
Emotions	Anger/irritability/ aggressiveness				
Mind	Confusion				
	Difficulty making decisions				
	Learning disabilities				
	Poor concentration				
	Poor memory				
	Poor coordination				
	Stuttering/Stammering				
Leave this row blank					
Page 1 Total					
Page 2 Total					
				Grand Total	

Exposure to Chemical Substances Questionnaire

Patient Name:_____ **Date:**_____

This questionnaire focuses on your exposure to common chemicals that may be impacting your health. Place a check mark (✔) in the box that best describes your experience with these substances.

Topic	Question	Yes	Leave this Column Blank
Medications			
Prescription Drugs	If you are currently taking prescription drugs indicate how many in the Yes column.		
	Does the normal dose help your medical condition?		
	Do you have drug side effects with a normal dose?		
	Have you lowered the dose to eliminate drug side effects?		
	Does the lowered dose work?		
Over the Counter Medications	Are you taking Cimetidine (Tagamet)?		
	Are you taking Acetaminophen?		
	Are you taking Estradiol?		
Stimulants			
Tobacco	Are you now, or within the last six months, regularly using tobacco?		
Caffeine	Do you have strong negative reactions to caffeine?		
Alcohol	Do you feel ill after consuming small amounts of alcohol?		
Chemical Exposure			
Odors/Fumes	Do you develop symptoms when exposed to fragrances, exhaust fumes or strong odors?		
Organic Chemicals	Have you had significant exposure to organic chemicals? Chemicals such as herbicides, insecticides, pesticides, or organic solvents?		
Sulfites	Do you have an allergic reaction to sulfites? **Note:** Sulfites are often found in red wine, dried fruit, and salad bar vegetables.		
Additional Personal History			
Indicate if you have a history of any of the following: ____ Brain fog ____ Fatigue ____ Drowsiness			
Environmental or chemical sensitivities			
Chronic Fatigue Syndrome			
Fibromyalgia			
Parkinson's type symptoms			
Alcohol or drug dependence			
Asthma			
	Total Number of Points		

Family Medical History

Patient Name:_____ Date: _____

		Immediate Family			Maternal					Paternal				
Medical Problem		Mother	Father	Siblings	Grandmother	Grandfather	Aunts	Uncles	Cousins	Grandmother	Grandfather	Aunts	Uncles	Cousins
Arthritis														
Asthma														
Auto-Immune Disease														
Blindness														
Cancer/Type														
Bronchitis														
Cholesterol														
Deafness	**Congenital**													
	Meniere's													
	Trauma													
Depression														
Diabetes														
Emphysema/Cause														
Heart Disease/Type														
Kidney Disease/Cause														
Learning Disabilities/Type														
Sciatica/Back Pain														
Seizures														
Stroke														
Thyroid Disease														
Ulcers/GI Disease														
Still Living?														
If Yes, how old _____														
If Deceased, what age _____														
Other														

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LEADING MEDICINE

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Informed Consent for Medical Treatment

Before your first visit with the doctor, it is necessary to read and sign this document. Feel free to ask questions to clarify any information you do not understand.

About Chiropractic Treatments
As a Doctor of Chiropractic, Dr. Maykel uses spinal manipulation therapy to treat his patients. This therapy is performed by using his hands or a mechanical instrument, called an activator. At times, you may hear a "click" or "pop", or feel a sense of movement in the area treated. This is normal. During the first few days after treatment, some patients feel stiffness and soreness which should go away.

Risks in Chiropractic Treatment
As with any medical procedure, there is the risk that complications may occur during spinal manipulation. During your examination, Dr. Maykel makes every reasonable effort to screen out contraindications to care. It is your responsibility to provide a complete medical history, including any existing medical conditions that may not come to the doctor's attention during a routine examination.

Complications
Complications are rare, but they may include fractures, disc injuries, muscle strain, cervical myelopathy, costovertebral strains, and separations. When a fracture does occur, it is usually due to an underlying weakness of the bone. Dr. Maykel checks for bone weakness during your examination. Some manipulations of the neck have been associated with injuries to the arteries, such as stroke. The estimated frequency of a stroke occurring from a spinal manipulation is between 1 in 1,000,000 and 1 in 5,000,000. Use of Other Treatment Options Other treatment options also carry risks. These option include self-medication with over-the-counter analgesics and rest; medical care and prescription drugs, including anti-inflammatory, muscle relaxants and pain killers; and hospitalization and/or surgery. Your primary care physician can discuss the risks and benefits of these other options. The Risk of Remaining Untreated
The greatest risk to your health occurs when your medical condition remains untreated. Adhesions may form, and you may experience a reduction in your mobility. This can set off a pain reaction and further reduce your movement. Over time, this approach may lead to additional complications, making it more difficult and less effective to treat.
Providing Consent

When you sign this document, you are providing consent to Dr. Maykel to the use a variety of medical procedures to examine, diagnose, and treat your condition. These procedures may include Muscle Strength Testing, Reviewing X-Rays, MRIs, CT Scans, Orthopedic Testing, Taking Vital Signs, Postural Analysis, Palpitations, Range of Motion Testing, Electric Stimulation, Basic Neurological Testing, Spinal Manipulation, and Cold Therapy.

I fully understand this document and consent to Chiropractic Treatment by Dr. Maykel.

Date

Print Name

Signature

Signature of Parent or Guardian

Signature, William M. Maykel, D.C., D.I.B.A.K.

WM WELLNESS MEDICINE // LEADING MEDICINE
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Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions of concerns regarding the use of dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Dr. Maykel's Notice of Privacy Practices for Protected Health Information.

✔ _____

Patient Name Printed

✔ _____

Patient Signature

✔ _____

Date

_____

Authorized Provider Representative

_____

Personal Representative Signature

_____

Description of personal representative's authority to act for the patient

WM WELLNESS MEDICINE
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