Life Enhancing Wellness Centers, LLC
Dr. Demetrios Kydonieus, ***Chiropractic Nutritionist***
8881 Seminole Trail
Ruckersville, Virginia 22968
(434) 481-2012 fax (888) 363-6358

Main Problems that I want help with from the doctor are?

Name _____DOB: _____ Today's Date _____

Please rate your pain: 1-10: 1=being the least painful, 10=excruciating, the worst-needs pain meds can't do much

Problem/accident related?(N/Y if :yes briefly describe)	WHEN did it START? -pain rating	How does the pain feel or how often? Constant, Frequent, On/Off, 1 x day, 2 x week, etc.	What makes it feel worse	What makes it feel better?
Example: *Low Back Pain/- fell down steps*	*Friday 2/2/2025 6*	*constant*	*sneezing , bending*	*Ice, rest, Tylenol*

**Extra boxes on next page if needed*

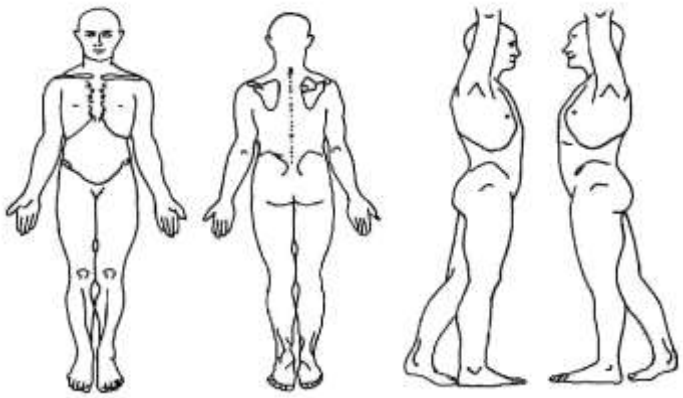
SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT ❑No pattern come/go

WHAT ACTIVITIES DO YOUR SYMPTOMS INTERFERE WITH? *(Check all that apply)*

❑Restless leg keeps me awake
❑Can't bend over - back pain
❑Hard to lift heavy things
❑Can't bend knee(s) that well
❑Can't get comfortable due to pain
❑Trouble sleeping due to pain
❑Weak grip dropping things
❑Hard to move my neck/turn head
❑Can't write well hands shake
❑Always tired hard to finish tasks
❑Fall asleep/staying asleep
❑Can't lose weight
❑Can't concentrate well
❑Bowel issues
❑Pain makes me irritable
❑Hard to stand > ____ minutes before it hurts

OTHER: _____

Mark the figure below where it hurts or you feel numb/tingling/radiating pains:



My worst symptoms are :
- ❑ ARE CONSTANT (76-100% of the day)
- ❑ ARE FREQUENT (51-75% of the day)
- ❑ ARE OCCASSIONAL (25-50% of the day)
- ❑ ARE INTERMITTANT 25% of the day)

❑**SUDDEN ONSET** (symptoms just appeared in the last few weeks)
❑**GRADUAL ONSET** (has been getting worse slowly over months or years

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Answer these questions:

"My main problem stops me from _____."

"I wish I could _____ again."

Is this a new car or workplace accident? *If not skip to next section*

(New accident means, pain from an accident that happened 3 months ago or less.)

ACCIDENT DATE:_____ Briefly describe _____
_____
_____
_____

Old injuries and accidents

PLEASE LIST or write "NONE" on this section if you have never been seriously injured.

Falls, beaten up, car accidents, sports injuries, broken bones, bicycle crashes, motor cycle, BMX crashes, "fell out the hay loft, etc. **BEFORE the current accident or problem you are here for now.** Please tell me about **any old broken bones** (all memorable accidents since childhood).

❑Job ❑Auto ❑Other 1. _____Date:_____

_____

❑Job ❑Auto ❑Other 2._____Date:_____

_____

❑Job ❑Auto ❑Other 3._____Date:_____

_____

❑Job ❑Auto ❑Other 4._____Date:_____

SURGICAL HISTORY:

Have you ever had a metal implant?❑Yes(where_____)❑No **Ever been gunshot?** ❑Yes_____ ❑No

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

4._____ Date:_____

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Name _____ Todays' Date _____

MEDICAL/FAMILY HISTORY **S = Self** M = Mother F = Father, Si=Sister, B=Brother

(Please indicate which conditions have been experienced by you and your family in the past, noted by marking appropriate boxes).

S	M	F	Si	B		S	M	F	Si	B		S	M	F	Si	B	
❑	❑	❑	❑	❑	AIDS/HIV	❑	❑	❑	❑	❑	dislocated joints	❑	❑	❑	❑	❑	neck pain
❑	❑	❑	❑	❑	**anemia**	❑	❑	❑	❑	❑	epilepsy	❑	❑	❑	❑	❑	nervousness
❑	❑	❑	❑	❑	arthritis	❑	❑	❑	❑	❑	**gout**	❑	❑	❑	❑	❑	numbness
❑	❑	❑	❑	❑	**asthma**	❑	❑	❑	❑	❑	**headaches**	❑	❑	❑	❑	❑	polio
❑	❑	❑	❑	❑	back pain	❑	❑	❑	❑	❑	**heart trouble**	❑	❑	❑	❑	❑	poor circulation
❑	❑	❑	❑	❑	**bladder issues**	❑	❑	❑	❑	❑	**hepatitis**	❑	❑	❑	❑	❑	reproductive disorders
❑	❑	❑	❑	❑	**bowel trouble**	❑	❑	❑	❑	❑	Hashimoto's thyroid	❑	❑	❑	❑	❑	**high blood pressure**
❑	❑	❑	❑	❑	bee allergy	❑	❑	❑	❑	❑	**indigestion**	❑	❑	❑	❑	❑	**rheumatoid arthritis**
❑	❑	❑	❑	❑	chest pain	❑	❑	❑	❑	❑	**kidney disorder**	❑	❑	❑	❑	❑	scarlet fever
❑	❑	❑	❑	❑	chronic allergy	❑	❑	❑	❑	❑	menstrual issues	❑	❑	❑	❑	❑	serious injury
❑	❑	❑	❑	❑	convulsions	❑	❑	❑	❑	❑	migraines	❑	❑	❑	❑	❑	sinus trouble
❑	❑	❑	❑	❑	concussion	❑	❑	❑	❑	❑	**multiple sclerosis**	❑	❑	❑	❑	❑	tuberculosis
❑	❑	❑	❑	❑	**diabetes**	❑	❑	❑	❑	❑	muscular dystrophy	❑	❑	❑	❑	❑	venereal disease
❑	❑	❑	❑	❑	**Cancer** explain_____												

Other family major illnesses_____

Have you been treated by a physician for <u>any health condition</u> in the last year? ❑Yes ❑No

If "yes" for what reason? _____

Personal medical doctor name_____ Phone #_____
Permission to contact them; ❑Yes ❑No
Describe reason for that doctor visit_____

Date of **Last Physical Exam** _____ By what type of doctor and where performed _____

Date of last chiropractic visit: _____ **(***"never"* if you have not ever seen a chiropractor)

Chiro Name _____ **Phone** _____ **State** _____

How many times did you see this chiropractor in the past and for what problems? _____

Nutritionist Name _____ **Phone** _____ **State** _____

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

NAME _____Email address: _____@_____

DOB: ___/___/_____ **Gender (Circle one):** Male / Female **Preferred Language: _____**

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____ Quit Date _____

Alcohol consumption: occasional; daily, weekly, rarely, never. Sober alcoholic, how many years? _____

CMS requires providers to report both race and ethnicity

Race (Circle one): African American, White (Caucasian), Hispanic, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander. I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications.

Medication Name	Dosage and Frequency (i.e. 5mg/day.) **what reason**
Ex: Lipitor	*10 mg/ 2 x day cholestorol*

Do you have any medication allergies?

Medication Name	Reaction	First Time noticed(Date)	Additional Comments

Patient Signature: _____Date: _____

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"What you eat affects your organ and muscle strength and will influence how fast you get well under our care. Good Nutrition is part of healing."

Name _____ **Today's Date** _____

Food Allergies if known: _____

Do you eat sugary foods regularly? Yes (weekly or daily) No

Do you drink sodas? Diet or Regular, Bottles(16oz) per day/week _____ **No**

Do you drink coffee? Cups/day? _____ **No ; Tea? Cups per day/week** _____ **No**

Do you CRAVE any foods on a regular basis? Yes (what?)_____ **No**

Servings of red meat (beef/pork) per week or day _____

Servings of game meat (venison, wild turkey, duck, goose, etc.) per week or day _____

Do you drink milk (circle all that apply: Raw, 2%, skim, whole? Organic or Regular) How much per day? _____

Servings of vegetables eaten per day (average day) _____
(A serving is the size of your palm)
Servings/pieces of fruit per day (average day) _____
(A serving is the size of your palm)
Do you eat bread/rolls? Slices/rolls per day _____ **No**

Do you take a multi vitamin? Yes No: Brand _____

Individual vitamin/herbs taken regularly in the past month (list brand if known)
_____

Ladies: ARE YOU PREGNANT ❑NO ❑YES **DATE OF LAST MENSTRUAL PERIOD**_____

Are your cycles regular? Days _____ ❑YES ❑NO **Is your flow heavy, regular or light?**

Do you miss periods sometimes over the last few years? If so how many/often? _____

Cramps: Mild Med Severe **Do they make your back hurt ?** ❑YES ❑NO

Painful intercourse? ❑YES ❑NO

MEN: Erectile issues? ❑NO ❑YES

Everyone:
Do you have a weight problem? ❑YES ❑NO **Do you want professional help with it?** ❑YES ❑NO

Frequent urination during the day? ❑YES ❑NO **If "Yes" How often** _____

Do you wake up at night to urinate? ❑YES ❑NO **If "Yes" How often** _____

Back pain during sex? ❑YES ❑NO

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Check ALL that apply to you now

As a result of my care at this office I would like to:

Check all that apply.

- ❑ Feel Better quickly
- ❑ Have a healthier body
- ❑ Stay healthy with regular Holistic check-ups so that my symptoms don't return again.
- ❑ Stop taking my current prescription medications safely.
- ❑ Live a better lifestyle
- ❑ Refer a someone I know for chiropractic and nutritional care to this clinic.

I give ***Life Enhancing Wellness Centers, LLC*** (Dr. Kydonieus) permission to email me.

Email: _____

Patient's Signature: _____ Date:_____

If you are a parent/guardian for a minor patient then sign below

Parent/Guardian name (print) _____

Relationship to minor patient _____

I give ***Life Enhancing Wellness Centers, LLC*** permission to test and treat my minor child, _____ as a patient. I also give my permission to treat my child in the future even if I am not present and send my child to this office (any location) with my appointed representative. If my child is of legal driving age but under 18 years of age and drives to this office for care and is alone I give my permission for them to receive treatment without me being present on such an occasion.

(*Minor's name*)

Legal Parent/Guardian, _____ _____

Signature Date

All permissions can be revoked at any time in writing. Such letters must be notarized and mailed "certified" US Postal Service or given to this office in person, signed and witnessed by our agent (employee). Email is not an acceptable form of notice to revoke said permissions noted above or elsewhere in this agreement.