

Date: \_\_\_\_\_

## The Cantrell Wellness Center

### Member Information

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(First, MI, Last)

Address: \_\_\_\_\_  
Street & Number City State Zip

Telephone: (\_\_\_\_) \_\_\_\_\_ Cell/mobile phone#: (\_\_\_\_) \_\_\_\_\_ Sex: \_\_\_\_\_

Email Address: \_\_\_\_\_

#### Marital Status

M S D W

#### Employment Status

Employed  Unemployed  Student  Retired

Your Employer: \_\_\_\_\_ Work Phone#: \_\_\_\_\_

### Spouse/Guardian Information

Spouse /Guardian Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First MI Last

Spouse's Employer Name: \_\_\_\_\_ Spouse Phone#: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

### How Did You Hear About Our Office?

\_\_\_ Former Patient Cantrell Center: Who? \_\_\_\_\_

\_\_\_ Yellow Pages: Which Publication? \_\_\_\_\_

\_\_\_ You were a former patient Cantrell Center. Date last seen. \_\_\_\_\_

\_\_\_ Employer: Who? \_\_\_\_\_

\_\_\_ Friend/Family

\_\_\_ Other: \_\_\_\_\_

**Friends of The Cantrell Center and The Cantrell Wellness Center are very special to us. Did anyone "other than" your physician recommend you to The Cantrell Wellness Center? We would like to thank them.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

# Personal Medical History

PLEASE CHECK ALL THAT APPLY:

SMOKE      DRINK      DRUGS      EXPOSED TO HIV      PREGNANT – IF SO, HOW LONG? \_\_\_\_\_

AIDS	HIGH BLOOD PRESSURE	PACEMAKER
ALLERGIES	HIGH CHOLESTEROL	PARKINSON'S DISEASE
CANCER	IMMUNE DEFICIENCY	PERIPHERAL NEUROPATHY
CEREBRAL PALSY	IMPAIRED VISION	RHEUMATOID ARTHRITIS
DIABETES	INCONTINENCE	SHORTNESS OF BREATH
EPILEPSY	INFECTIOUS HEPATITIS	STROKE
EXCESSIVE BLEEDER	JOINT REPLACEMENT	SWELLING
FIBROMYALGIA	LUPUS	TUMOR
FRACTURES	MIGRAINES	
GOUT	MULTIPLE SCLEROSIS	OTHER:
HEART CONDITION	OSTEOPOROSIS	

Are you under the care of a cardiologist? If so, who? \_\_\_\_\_

Please list your medications and indicate the reason you have been prescribed each:

**Medication:** \_\_\_\_\_ prescribed for: \_\_\_\_\_  
**Medication:** \_\_\_\_\_ prescribed for: \_\_\_\_\_  
**Medication:** \_\_\_\_\_ prescribed for: \_\_\_\_\_  
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**Medication:** \_\_\_\_\_ prescribed for: \_\_\_\_\_  
**Medication:** \_\_\_\_\_ prescribed for: \_\_\_\_\_

Are you currently experiencing any pain? If so, then describe symptoms and location:

\_\_\_\_\_  
 \_\_\_\_\_

Physician seen for wellness physical: \_\_\_\_\_ Date of visit: \_\_\_\_\_

May we send progress reports to him/her?       Yes       No

Who is your family physician? (Primary Care Physician) \_\_\_\_\_

May we send progress reports to him/her?       Yes       No

Would you be interested in Personal Training? \_\_\_\_ Yes \_\_\_\_ No

Would you be interested in attending a Fitness Boot Camp? \_\_\_\_ Yes \_\_\_\_ No

Would you be interested in attending educational seminars? \_\_\_\_ Yes \_\_\_\_ No

What personal fitness goal would you like to achieve here at the Cantrell Wellness Center?

\_\_\_\_\_  
 \_\_\_\_\_

What area of your body would you like to improve on the most? \_\_\_\_\_

How many times a week do you see yourself using the facility? \_\_\_\_\_