



Confidential Patient Information

Your privacy is important to us. We comply with all Health Information Patient Protection Act rules, regulations and laws. Our HIPPA Compliance Manual is available for your review.

First Name:

Last Name:

Initial:

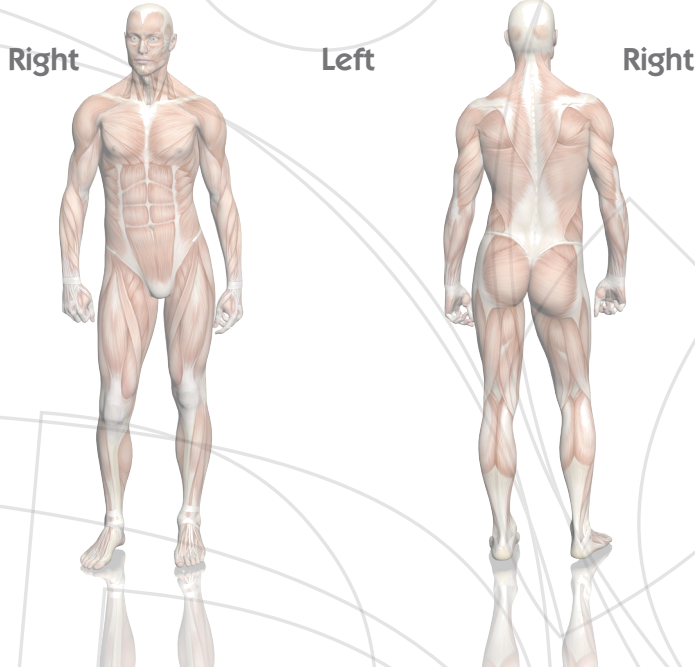
Major Complaint Information

What is your major complaint?

When did this symptom(s) begin?

If this is an injury, describe what happened?

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. [1 being minor, 10 being severe.]



Pain Index

- D** Dull Nagging Ache
- B** Burning
- S** Sharp / Stabbing
- N** Numbness / Tingling
- M** Muscle Spasm / Pulling

For example: if you are experiencing moderately severe burning pain in back of your neck, you should note a "B8" on the neck of the illustration.

On a scale of 1-10, how do you feel now? (1 being best, 10 being the worst)



How often do you experience your symptoms?

- Constantly [76-100% of the time]
- Frequently [51-75% of the time]
- Occasionally [26-50% of the time]
- Intermittently [1-25% of the time]

How would you describe the type of pain?

- Sharp
- Dull
- Diffuse
- Achy
- Burning
- Shooting
- Stiff
- Numb
- Tingly
- Sharp with Motion
- Shooting with Motion
- Stabbing with Motion
- Electric like with Motion
- Other:

How are your symptoms changing with time?

Getting Worst

Staying the Same

Getting Better

Using a scale from 0-10 [10 being worst], how would you rate your problem?



How much has the problem interfered with your work?

Not At All

A Little Bit

Moderately

Quite a Bit

Extremely

How much has the problem interfered with your social activities?

Not At All

A Little Bit

Moderately

Quite a Bit

Extremely

Who else have you seen for your problem?

Chiropractor

ER Physician

Massage Therapist

Neurologist

Orthopedist

Physical Therapist

Primary Care Physician

Other:

No One

What aggravates your problem?

What alleviates your problem?

Headache Supplement

Do you get headaches? Yes No Frequency:

Do you have a family history of headaches? Yes No

Do you experience the following conditions along with your headaches:

Pain or cracking in your jaw? Yes No

Abnormal blood pressure? Yes No High Low

Nausea, Vomiting or Visual disturbances? Yes No

When was your last eye exam by a doctor? 1-6 Months 6-12 Months 1-2 Years

Over 2 Years Results:

What concerns you the most about your problem; what does it prevent you from doing?

What is your:

Height:

Weight:

Age:

Occupation:

How would you rate your overall health?

Excellent

Very Good

Good

Fair

Poor

What type of exercise do you do?

Strenuous

Moderate

Light

None

List all prescription medications you are currently taking:

List all of the over-the-counter medications you are currently taking:

Have you ever been hospitalized? Yes No If YES, why?

List all surgical procedures you have had:

For each of the conditions listed below, place a check in the "Past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Present" column.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Headaches*	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid-Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Low-Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss	For Female Patients Only		
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	Due Date:		Comments
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder			
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue			
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness			
<input type="checkbox"/>	<input type="checkbox"/>	Other:						

Indicate if you have any immediate family members with any of the following:

- | | | |
|-----------------------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> ALS | |

What activities do you do at work?

- | | | | |
|----------------------------------------|------------------------------------------|------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Sit | <input type="checkbox"/> Most of the Day | <input type="checkbox"/> Half of the Day | <input type="checkbox"/> A Little of the Day |
| <input type="checkbox"/> Stand | <input type="checkbox"/> Most of the Day | <input type="checkbox"/> Half of the Day | <input type="checkbox"/> A Little of the Day |
| <input type="checkbox"/> Computer Work | <input type="checkbox"/> Most of the Day | <input type="checkbox"/> Half of the Day | <input type="checkbox"/> A Little of the Day |
| <input type="checkbox"/> On the Phone | <input type="checkbox"/> Most of the Day | <input type="checkbox"/> Half of the Day | <input type="checkbox"/> A Little of the Day |

What activities do you do outside of work?

Have you had a significant past trauma or motor vehicle accident? Yes No

If YES, please explain:

Anything else pertinent to your WellnessOne visit today?

If your visit today is an accidental injury, please complete the Personal Injury Supplemental Questionnaire. Thank you.

Personal Information

Residence Address:

City/State/Zip

Mailing Address:

City/State/Zip

Home Telephone

Mobile Telephone:

Social Security Number:

Birthday:

State Driver's License Number:

Work Telephone:

Email Address:

Gender: Male Female

Employer's Name:

Work Address:

City/State/Zip

Marital Status: Single Married Divorced Widow/Widower

Spouse Name:

Number of Children:

Primary Care Physician

Address

City/State/Zip

Telephone

Previous Chiropractor:

Dates Under Care:

How were you referred to WellnessOne?

- | | | | | |
|----------------------------------------|----------------------------------------------|---------------------------------------|-------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> WO Patient | <input type="checkbox"/> Attorney | <input type="checkbox"/> Newspaper | <input type="checkbox"/> Billboard | <input checked="" type="checkbox"/> Health Fair |
| <input type="checkbox"/> Family Member | <input type="checkbox"/> M.D. | <input type="checkbox"/> Magazine | <input type="checkbox"/> Radio | <input type="checkbox"/> Community Event |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Healthcare Provider | <input type="checkbox"/> Mailer | <input type="checkbox"/> Television | <input type="checkbox"/> Other: Describe |
| <input type="checkbox"/> Co-Worker | <input type="checkbox"/> Insurance Plan | <input type="checkbox"/> Web Site | <input type="checkbox"/> Spinal Screening | |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Yellow Page | <input type="checkbox"/> Social Media | <input type="checkbox"/> Speech | |

Emergency Contact

Name:

Relationship:

Home Telephone:

Work Telephone:

Mobile Telephone:

Email:

Address:

City/State/Zip

Your Insurance Information

No Insurance

Health Insurance Company:

Your Insurance I.D. Number:

Address:

City/State/Zip:

Telephone

Insured's Name:

Employer:

Birthday:

S.S. Number:

Automobile Insurance Company:

Policy Number:

Address:

City/State/Zip:

Telephone

Insured's Name:

Birthday:

WellnessOneSB ID:

The information you provided will enable you to enjoy a healthier and more active lifestyle. Your WellnessOne doctor will carefully review your information with your approval on the last page. Thank you.

Patient I.D.	WOID	GCID	Other

Authorization and Assignment

I authorize WellnessOne to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint WellnessOne the authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with WellnessOne when said payments are due to services rendered on behalf of the undersigned by WellnessOne.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Informed Consent

I hereby authorize physicians and staff at WellnessOne to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of WellnessOne responsible for any errors or omissions that I may have made in the completion of this form or additional supplemental forms.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness: Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury: Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft-tissue injury.

Rib Injury: Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns: Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke: Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems: There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date:

Patient/Guardian Signature:

Witness: