Wellness Matters Chiropractic

A natural approach to pain relief and wellness

Welcome to the Office

Date _____ First Name_____ M.I. ____ Last Name _____

Address _____ City/State/ZIP _____

Home/Cell Phone# _____ Work Phone _____ Spouse's phone _____

Email _____ Driver's License # _____

Social Security # _____-____-_____ Birth Date _____ Age _____ Sex ____

Marital Status S M D W Spouse/Partner's Name _____

Children(s) Names and ages: _____

Employer _____ Occupation _____

Spouse's Employer _____ Spouse's Occupation _____

Emergency Contact & phone # _____ Relationship _____

How were you referred to our office? _____

Have you ever had Chiropractic care before? _____ If yes, when and where? _____

Please check reasons for consulting the office:

_____ I am interested in wellness and natural health care
_____ I am in pain and need help
_____ I had a personal injury or accident
_____ Other

- Is this injury/illness work-related? _____ Have you reported it to your employer? _____

FINANCIAL POLICY

Our policy requires payment in full for the first visit for all services rendered at the time of service. We will not file insurance but we will provide you with a superbill that you can turn in to your insurance at your request. We do accept Medicare patients. You are ultimately financially responsible for all charges incurred on your account. You further understand and agree that if your account is not paid within 90 days from the date of service (and other payment arrangements have not been made) the assistance of a collection agency will be enlisted and you will be responsible for any expenses incurred in collecting your account.
No call/no show appointments (if not cancelled 24 hours before) will be subjected to a $25 fee. All return checks are subject to a $30 processing fee.

Method of payment: Cash _____ Check _____ Credit/Debit _____

By my signature I agree that all information given is complete and accurate to the best of my knowledge. I understand that all information given is completely confidential.

Patient Signature _____ Date _____

PRIVACY PRACTICES – PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (3 pages in the back on clip board or on our website) for Wellness Matters Chiropractic and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.
I understand that this office will properly maintain my records and will use all due means to protect my privacy as outlined in this privacy practices statement.

Signature _____ Printed Name _____Date_____

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:
a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;
b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may
be caused, by spinal or soft tissue manipulation or treatment.
c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms.
Musculoskeletal care contributes to your overall well-being. ***The risk of injuries of complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:
a. The condition that the treatment is to address;
b. The nature of the treatment;
c. The risks and benefits of that treatment; and
d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.
I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care at Wellness Matters Chiropractic LLC.

Signature _____ Printed Name _____

Wellness Matters Chiropractic

A natural approach to pain relief and wellness

Name:_____ **Date:** _____

Welcome to Wellness Matters Chiropractic.

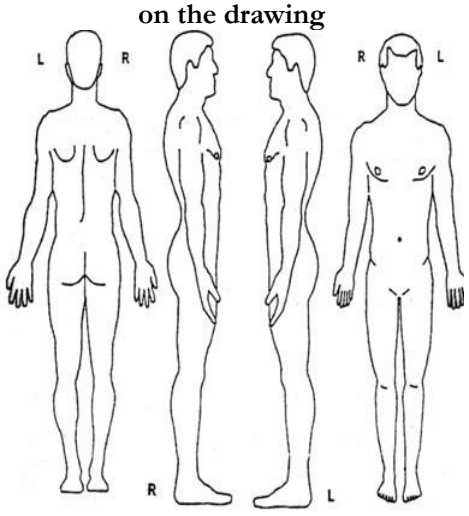
History of Present Complaint

1. What is your major complaint? _____
2. Date of onset _____ Gradual or sudden onset? _____
3. Is this condition due to an □ Auto Accident □ Work Injury □ Other Accident □ Unknown cause □ Illness
4. What is the severity of pain/discomfort on a scale of 0-10 (0 is no pain, 10 is the worst you have ever experienced) ___
5. How long does an episode last approximately? □ Minutes □ Hours □ Intermittent □ Constant
6. When do you notice it most? AM/PM
5. Other complaints? Please describe: _____
6. Are the symptoms: □ Improving □ Getting worse □ About the same □ Intermittent (come and go)
7. What makes it better? _____ What makes it worse? _____
8. Type of pain: sharp dull aching burning throbbing cramping numbness tingling other : _____
9. Have you had these symptoms before? _____ If so, when? _____
10. Do you have any difficulty performing any of the following activities: (circle all that apply)

    Personal Care – Lifting – Reading – Working – Driving – Walking – Sitting – Standing – Social Life - Exercise
11. Have you seen another doctor for this condition? _____ Dr.'s Name & Location: _____

    Date consulted _____ Diagnosis _____

Please mark areas of pain on the drawing



Family History (Please put appropriate symbol in each box that applies to family history) F = Father M = Mother S = Sister B = Brother

Diabetes	Cancer	Heart	Bld. Pres.	Chol.	Kidney	Scoliosis	Back Problems
□	□	□	□	□	□	□	□
□	□	□	□	□	□	□	□
□	□	□	□	□	□	□	□
□	□	□	□	□	□	□	□

Depression	Nerves	Rheum. Arth.	MS	Psoriasis	Asthma	Thyroid	Lupus
□	□	□	□	□	□	□	□
□	□	□	□	□	□	□	□
□	□	□	□	□	□	□	□
□	□	□	□	□	□	□	□

Chemical Sensitivity	Atopic Dermatitis
□	□
□	□
□	□
□	□

Cause of death:
Mother: _____
Father: _____
Brother: _____
Sister: _____

Name: _____ **Date:** _____

Please complete the following review of your health picture.
While these conditions may not seem directly related to the reason you are here,
this information will help the doctor get a better idea of your overall health, past and present.
Please indicate any conditions that you have presently, or have had in the past, with the onset year.

Childhood Illnesses:
___ ADD/ADHD ___ Allergies ___Anemia ___ Asthma ___ Bedwetting ___ Cerebral Palsy ___ Diabetes
___ Ear Infection ___ Fetal Drug Exposure ___ Food Allergies: _____
___ Headaches ___ Measles ___ Mumps ___ Psoriasis ___ Scoliosis ___ Seizures ___ Spina Bifida

Adult Illnesses:
___ Alzheimer's ___ Anemia ___Arthritis ___ Asthma ___ Cancer ___ Crohn's/colitis ___ CVA (stroke)
___ Cystic kidney disease ___ Depression ___ Diabetes (insulin dep./non insulin dep.) ___ Eczema
___ Emphysema ___ Eye Problems ___ Fibromyalgia ___ Heart Disease ___ Hepatitis ___ HIV
___ Hypertension ___ Liver Disease ___ Lung Disease ___ Lupus ___ Multiple Sclerosis ___ Parkinson's
___ Pneumonia ___ Psoriasis ___ Psychiatric concerns ___ Scoliosis ___ Seizures ___ Shingles
___ STD ___ Suicide attempt(s) ___Thyroid problems ___ Vertigo ___ Other: _____

Injuries: (Please list date and explanation)
___ Back injury ___ Broken bones ___ Head injury ___ Loss of consciousness ___ Industrial accident
___ Joint injury ___ Auto Accident (Date(s) _____ ___ Laceration
___ Other: _____
Explanation _____
_____

Surgeries: (Please list any surgeries you have had with the date)
___ Tonsillectomy ___ Appendectomy ___ Gall Bladder ___ Back surgery ___ Tubes in ears ___ Female Organs
___ Rectal Surgery ___ Other: _____
_____

Medications & Vitamins: (Please list your current medications and vitamins and the dosages)
_____
_____
Do you have any known adverse drug reactions? _____

Females ONLY:
Pregnancy History:
___ # of complicated pregnancies ___ # of uncomplicated pregnancies ___ # of C-Sections
___ # of vaginal deliveries ___ # of miscarriages ___ # of terminated pregnancies
Menstrual History:
___ regular ___ irregular ___ age of first menses ___ age when menopause began

Wellness Matters Chiropractic

A natural approach to pain relief and wellness

Name:_____ **Date:** _____

Review of Systems

Often seemingly unrelated complaints that you might not think to mention indicate a pattern in the bigger picture of holistic health. Please check accordingly:

1= Previously experienced 2= Occasionally experienced 3= Presently experienced 4= Presently severe

General Symptoms	1	2	3	4
Headache	□	□	□	□
Fever	□	□	□	□
Chills	□	□	□	□
Night Sweats	□	□	□	□
Fainting	□	□	□	□
Dizziness	□	□	□	□
Convulsions	□	□	□	□
Loss of Sleep	□	□	□	□
Fatigue	□	□	□	□
Nervousness	□	□	□	□
Loss of Weight	□	□	□	□
Numbness/pain of arms/legs/hands	□	□	□	□
Allergy_____	□	□	□	□
Wheezing	□	□	□	□

Gastro-intestinal	1	2	3	4
Poor Appetite	□	□	□	□
Poor Digestion	□	□	□	□
Belching or gas	□	□	□	□
Nausea/Vomiting	□	□	□	□
Vomiting blood	□	□	□	□
Constipation	□	□	□	□
Diarrhea	□	□	□	□
Colon Trouble	□	□	□	□
Hemorrhoids	□	□	□	□
Liver Trouble	□	□	□	□
Jaundice	□	□	□	□
Gallbladder	□	□	□	□
Abnormal Stool	□	□	□	□
Gastritis/Ulcer	□	□	□	□

Eye/Ear/Nose/Throat	1	2	3	4
Poor Vision	□	□	□	□
Crossed Eyes	□	□	□	□
Pain in Eyes	□	□	□	□
Deafness R/L	□	□	□	□
Earache	□	□	□	□
Ear Noises (Tinnitus)	□	□	□	□
Nose Bleeds	□	□	□	□
Sore Throat	□	□	□	□
Hoarseness	□	□	□	□
Hay Fever	□	□	□	□
Asthma	□	□	□	□
Frequent Colds	□	□	□	□
Tonsillitis	□	□	□	□
Sinus Trouble	□	□	□	□

Muscles & Joints	1	2	3	4
Weakness	□	□	□	□
Twitching	□	□	□	□
Stiff Neck	□	□	□	□
Sore Throats	□	□	□	□
Backache	□	□	□	□
Swollen Joints	□	□	□	□
Tremors	□	□	□	□
Foot Trouble	□	□	□	□
Hernia	□	□	□	□
Spinal Curvature	□	□	□	□
Pain betw. Shoulders	□	□	□	□

Skin or Allergies	1	2	3	4
Skin Eruptions	□	□	□	□
Itching	□	□	□	□
Bruising easily	□	□	□	□
Dryness	□	□	□	□
Boils	□	□	□	□
Sensitive Skin	□	□	□	□
Hives or Allergies	□	□	□	□
Eczema	□	□	□	□
Vaginal Discharge	□	□	□	□

Respiratory	1	2	3	4
Chronic Cough	□	□	□	□
Spitting blood	□	□	□	□
Spitting Phlegm	□	□	□	□
Chest Pain	□	□	□	□
Difficulty Breathing	□	□	□	□

Cardiovascular	1	2	3	4
Rapid Heart	□	□	□	□
Slow Heart	□	□	□	□
High Blood Pres.	□	□	□	□
Low Blood Pressure	□	□	□	□
Pain over Heart	□	□	□	□
Prev. heart trouble	□	□	□	□
Swelling Ankles	□	□	□	□
Poor Circulation	□	□	□	□
Varicose Veins	□	□	□	□
Stroke	□	□	□	□

Genito-Urinary	1	2	3	4
Frequ. Urination	□	□	□	□
Painful Urination	□	□	□	□
Blood in urine	□	□	□	□
Kidney Infection	□	□	□	□
Bed Wetting	□	□	□	□
Prostate Trouble	□	□	□	□
Inability to control urine	□	□	□	□

Female Conditions	1	2	3	4
Painful Periods	□	□	□	□
Excessive Flow	□	□	□	□
Irregular Cycle	□	□	□	□
Hot Flashes	□	□	□	□
Cramps or Backache	□	□	□	□
Vaginal Discharge	□	□	□	□
Vaginal Yeast Infection	□	□	□	□

Name:_____ **Date:** _____

Tests and Immunizations (Please provide approximate dates)

Blood Profile _____
Breast Exam _____
Breast Mammography _____
CBC _____
Chest X-Ray _____
Cholesterol, Triglycerides _____
Complete Physical _____
EKG _____
Enlarged Heart _____
Flu Shot _____
Genitalia Exam (Male) _____
HIV Test _____
PAP Smear _____
Pneumonia Vaccine _____
Pulmonary Function _____
Rectal Exam _____
Sigmoidoscopy _____
Sodium & Potassium _____
Stool, Occult Blood _____
Tetanus (DPT) _____
Treadmill Test _____
Urinalysis _____

Social History

- Do you use tobacco products? Y/N What type? _____ How much per day? _____
- Do you drink alcohol? Y/N What kind? _____ How much per week? _____
- Do you drink coffee? Y/N How many cups per day? _____
- Do you drink sodas? Y/N How many cups per week? _____
- Any other types of stimulants? Y/N What kind? _____ How much per week? _____
- Do you exercise? □ None □ Occasional □ Weekly □ Daily Details: _____
- How well do you sleep and in what position? _____
- What level of lifestyle stress would you estimate you have? (0-10, 0=no stress, 10=the worst you ever had)

  _____

The above information is complete and accurate to the best of my knowledge.

Patient's signature _____ Date _____