



**Patient Information**

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Legal Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Preferred Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Gender at birth  F  M Height \_\_\_\_\_ Weight \_\_\_\_\_

Married  Yes  No Spouse Name \_\_\_\_\_ # of Children \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Relation \_\_\_\_\_ Emergency # \_\_\_\_\_

**How Did You Hear About Us?**

Current TWW Patient Patient Name \_\_\_\_\_

Social Media Which Platform \_\_\_\_\_

Other \_\_\_\_\_

**Employment Information**

Employed  Yes  No Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer City \_\_\_\_\_ Employer State \_\_\_\_\_ Employer Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Work Supervisor \_\_\_\_\_ Supervisor # \_\_\_\_\_

Work Duties \_\_\_\_\_

**Reason for this visit:**

Describe the reason for this visit

When did this concern begin? \_\_\_\_\_ Has this concern  Gotten Worse  Stayed Constant  Comes and Goes

Does this concern interfere with?  Work  Sleep  Daily Routine  Other Activities

Briefly Explain \_\_\_\_\_



Patient Name \_\_\_\_\_

**Reason for this visit** (continued)

Has this concern occurred before?  Yes  No Briefly Explain \_\_\_\_\_

Have you seen other doctors for this concern?  Yes  No

Type of treatment \_\_\_\_\_

**Did an Injury Occur?** If yes, complete the following

Work  Automobile  Home  Other Injury Date \_\_\_\_\_

Injury Origin \_\_\_\_\_

Describe Discomfort \_\_\_\_\_

**Information Regarding Your Concern**

Interfere w/ Activities  Yes  No Affected Sleep  Yes  No Frequency \_\_\_\_\_

Missed Work  Yes  No Unable to work from \_\_\_\_\_ Unable to work until \_\_\_\_\_

Affected Appetite  Yes  No Explain \_\_\_\_\_

Reduced Work  Yes  No Explain \_\_\_\_\_

Does it Worsen  Yes  No Explain \_\_\_\_\_

Weather Affects it  Yes  No Explain \_\_\_\_\_

What Aggravates Condition \_\_\_\_\_

What Improves Condition \_\_\_\_\_

Received Treatment  Yes  No Explain \_\_\_\_\_

X-rays Taken  Yes  No Explain \_\_\_\_\_

Pain Level Rating (Scale 1-10, 10 being worst) At its best \_\_\_\_\_ At its worst \_\_\_\_\_ Current Level \_\_\_\_\_

Current Medications (Prescribed or over-the-counter) \_\_\_\_\_

Current Supplements \_\_\_\_\_

**For cycling females only**

Age of first period \_\_\_\_\_

Are you pregnant?  Yes  No

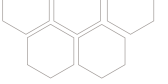
Are you nursing?  Yes  No

Are you taking birth control?  Yes  No

If yes, which one? \_\_\_\_\_

Do you have regular cycles?  Yes  No

Menses frequency \_\_\_\_\_ Length of cycle \_\_\_\_\_



Patient Name \_\_\_\_\_

**For cycling females only** (continued)

Do you have missed periods?  Yes  No      Do you experience painful periods?  Yes  No

Do you have clotting?  Yes  No      Are you menopausal?  Yes  No

Do you have breast implants?  Yes  No

How many pregnancies have you had? \_\_\_\_\_ Have you had any miscarriages?  Yes  No    If yes, How many? \_\_\_\_\_

How many living children do you have? \_\_\_\_\_

**Social Activity Information**

<b>Alcohol</b> <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	<b>Caffeine</b> <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never
<b>Diet Food Products</b> <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	<b>Drugs</b> <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never
<b>OTC Stimulants</b> <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	<b>Exercise</b> <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never
<b>Homemade Food</b> <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	<b>Processed Food</b> <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never
<b>Soft Drinks</b> <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	<b>Tobacco</b> <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never
<b>Water</b> <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	

**Patient Health History**

Previous Chiropractic Care  Yes  No      Date of Last Adjustment \_\_\_\_\_

Reason \_\_\_\_\_

Last Physical Exam \_\_\_\_\_      Primary Physician \_\_\_\_\_      Physician Phone \_\_\_\_\_

Physician City \_\_\_\_\_      Physician State \_\_\_\_\_      Physician Zip \_\_\_\_\_

Health Conditions \_\_\_\_\_

Broken Bones  Yes  No      Treatment  Yes  No      Explain \_\_\_\_\_

Sprains/Strains  Yes  No      Treatment  Yes  No      Explain \_\_\_\_\_

Hospitalized  Yes  No      Explain \_\_\_\_\_

Surgery  Yes  No      Explain \_\_\_\_\_

Auto Accident  Yes  No      Explain \_\_\_\_\_

Struck Unconscious  Yes  No      Explain \_\_\_\_\_

Eating Disorder  Yes  No      Explain \_\_\_\_\_

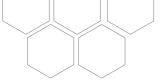
Stroke  Yes  No      Explain \_\_\_\_\_



Patient Name \_\_\_\_\_

**Patient Health History** (continued)

- |   |  |   |
|---|--|---|
| <input type="radio"/> ADHD  | <input type="radio"/> Diagnosed Emotional/Mental           | <input type="radio"/> Nosebleeds              |
| <input type="radio"/> Alcoholism  | <input type="radio"/> Digestion Problems                   | <input type="radio"/> Pacemaker               |
| <input type="radio"/> Allergies   | <input type="radio"/> Dizziness                            | <input type="radio"/> Parkinson's             |
| <input type="radio"/> Anemia  | <input type="radio"/> Ear Infections                       | <input type="radio"/> Polio                   |
| <input type="radio"/> Arteriosclerosis  | <input type="radio"/> Epilepsy                             | <input type="radio"/> Poor Posture            |
| <input type="radio"/> Arthritis   | <input type="radio"/> Excessive Menstruation               | <input type="radio"/> Prostate Trouble        |
| <input type="radio"/> Asthma  | <input type="radio"/> Eye Pain or Difficulties             | <input type="radio"/> Reflux                  |
| <input type="radio"/> Autoimmune Disease:<br>_____  | <input type="radio"/> Fatigue                              | <input type="radio"/> Recurring Fevers        |
|   | <input type="radio"/> Frequent Urination                   | <input type="radio"/> Retinal Disease         |
| <input type="radio"/> Back Pain   | <input type="radio"/> Gallbladder Disease/Stones           | <input type="radio"/> Rubella                 |
| <input type="radio"/> Bed Wetting   | <input type="radio"/> Glaucoma                             | <input type="radio"/> Sciatica                |
| <input type="radio"/> Bleeding Disorders  | <input type="radio"/> Gout                                 | <input type="radio"/> Scoliosis               |
| <input type="radio"/> Breast Lump   | <input type="radio"/> Growing Pains                        | <input type="radio"/> Seizures                |
| <input type="radio"/> Bronchitis  | <input type="radio"/> Headache                             | <input type="radio"/> Shortness of Breath     |
| <input type="radio"/> Bruise Easily   | <input type="radio"/> Hemorrhoids                          | <input type="radio"/> Sinus Infection         |
| <input type="radio"/> Bypass Surgery  | <input type="radio"/> Hormone Replacement                  | <input type="radio"/> Skin Sensitivity        |
| <input type="radio"/> Cancer  | <input type="radio"/> Hot Flashes                          | <input type="radio"/> Sleep Problems/Insomnia |
| <input type="radio"/> Cataracts   | <input type="radio"/> Hypertension                         | <input type="radio"/> Smoker                  |
| <input type="radio"/> Chest Pain  | <input type="radio"/> Irregular Heart Beat                 | <input type="radio"/> Spinal Curvatures       |
| <input type="radio"/> Chicken Pox   | <input type="radio"/> Irregular Menstrual Cycle            | <input type="radio"/> Stroke                  |
| <input type="radio"/> Chronic Colds   | <input type="radio"/> Irritable Bowel Syndrome (IBS)       | <input type="radio"/> Swelling of Ankles      |
| <input type="radio"/> Cold Extremities  | <input type="radio"/> Kidney Infection                     | <input type="radio"/> Swollen Joints          |
| <input type="radio"/> Colic   | <input type="radio"/> Kidney Stones                        | <input type="radio"/> Temper Tantrums         |
| <input type="radio"/> Congestive Heart Failure  | <input type="radio"/> Liver Disease/Cirrhosis              | <input type="radio"/> Thyroid Condition       |
| <input type="radio"/> Constipation  | <input type="radio"/> Loss of Balance                      | <input type="radio"/> Tuberculosis            |
| <input type="radio"/> COPD/Emphysema  | <input type="radio"/> Loss of Memory                       | <input type="radio"/> Ulcers                  |
| <input type="radio"/> Coronary Artery Disease   | <input type="radio"/> Loss of Smell                        | <input type="radio"/> Varicose Veins          |
| <input type="radio"/> Cramps  | <input type="radio"/> Loss of Taste                        | <input type="radio"/> Venereal Disease        |
| <input type="radio"/> CVA (Stroke/Transient Ischemic Attack)                              | <input type="radio"/> Lung Disease                         | <input type="radio"/> Whooping Cough          |
| <input type="radio"/> Dementia/Alzheimer's  | <input type="radio"/> Macular Degeneration                 | <input type="radio"/> Other: _____            |
| <input type="radio"/> Depression  | <input type="radio"/> Measles (Rubeola)                    | _____   |
| <input type="radio"/> Diabetes  | <input type="radio"/> Migraines                            | _____   |
| <input type="radio"/> Type I <input type="radio"/> Type II <input type="radio"/> Juvenile | <input type="radio"/> Myocardial Infarction (Heart Attack) |   |



Patient Name \_\_\_\_\_

**Patient Birth History**

Did patient's mother...

- Have birth intervention?       Forceps    Vacuum Extraction    Caesarian Section
- Have an emergency or planned delivery?       Yes    No
- Have ultrasounds during pregnancy?       Yes    No   If yes, how many? \_\_\_\_\_
- Have medications during pregnancy/delivery?    Yes    No   If yes, please list \_\_\_\_\_
- Use cigarettes or alcohol during pregnancy?    Yes    No   If yes, how much and how often? \_\_\_\_\_

**Family Health History**

- Mother       Living    Deceased   Cause of Death \_\_\_\_\_
- Maternal Grandmother    Living    Deceased   Cause of Death \_\_\_\_\_
- Maternal Grandfather    Living    Deceased   Cause of Death \_\_\_\_\_
- Father       Living    Deceased   Cause of Death \_\_\_\_\_
- Paternal Grandmother    Living    Deceased   Cause of Death \_\_\_\_\_
- Paternal Grandfather    Living    Deceased   Cause of Death \_\_\_\_\_

**Insurance Information**

Please provide a copy of your driver's license and insurance card(s).

**Terms of Acceptance**

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to The Wellness Way Clinics. I authorize The Wellness Way and it's staff to examine and deliver care as they see fit. I thereby authorize The Wellness Way to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that there is a 48 business hour cancellation policy for new patient and consultation appointments. Failure to comply with the cancellation policy may result in additional charges. A \$25 fee will be applied to all NSF checks. By signing below, I agree to the financial policy described above and will adhere to all of it's practices.

Signature \_\_\_\_\_

Date \_\_\_\_\_