PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to assist you. (Please Print)

Name _____Today's Date_____ Date of Birth _____ Age _____ □ Female □ Male
Address _____City _____ State _____Zip _____
Home phone _____Work phone _____ Cell Phone _____
Your employer _____ Occupation_____
Are you: □ Minor □ Married □ Divorced □ Widowed □ Single □ Separated Do you have children? Y / N
Spouse or Parent's name _____ Emergency contact name and Phone #_____
How did you find out about us? _____Email address (office newsletters):_____
May we leave a message on your machine or with someone? Y / N If yes, who?_____
What type of message may we leave? □ only to ask for a return call □ appointment information only □ any detail necessary
Preferred language? □ English □ Other_____ Ethnicity? □ I do not wish to provide □ Hispanic/Latino □ Non Hispanic/Latino
Race? □ I do not wish to provide □ White □Asian □ Black/African American □ Native Hawaiin/Pacific Islander □ Other:_____
Smoking Status? □ Never □ Former Smoker : stop date_____ □ Current every day : start date_____ □ Current some days
Do you have any medication allergies? Y / N Which?_____
Are you currently taking any medications? Y / N Please List or provide a list: _____
_____

Preferred form of Communication: □ Email □ Us Postal □ In Person □ Cell □ Home □ Work □ Other:_____

Type of claim: □ Cash □ Group Health Insurance □ Personal Injury □Worker's Comp □ Medicare □ Medicaid □ Other:_____

INSURANCE INFORMATION

Primary —*please present card to receptionist.*
Insurance _____ Primary Insured Name _____
Policy #_____Primary Insured's Date of Birth _____/_____/_____Relationship to Insured_____
Home address if different from patient
_____

Secondary —*please present card to receptionist.*
Insurance _____ Primary Insured Name _____
Policy #_____Primary Insured's Date of Birth _____/_____/_____Relationship to Insured_____
Home address if different from patient
_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize Essence of Wellness to release any information including diagnosis, records, treatment and examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners including but not limited to my primary care physician.

I authorize the use of this form as consent for Essence of Wellness Chiropractic Center to obtain medical records from any physician or healthcare facility for which I have been treated by/at.

FINANCIAL RESPONSIBILITY

I authorize and request my insurance company to directly pay the chiropractor for group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services rendered.. I understand I am responsible for services provided by the doctors or therapists, even though, my insurance company may determine them to be not medically necessary, a non-covered service, or an out of network service. Any unpaid balance not paid by the insurance is the patient's responsibility. I agree to be responsible for payment of all services rendered to me or my dependents. Payment for services are due at the time services are rendered unless other arrangements have been approved in advance by our staff. We will charge you based on your insurance quote until we received notice or payment from your insurance carrier. Your claims will be filled as a courtesy and our fees normally fall within the Usual, Customary, and Reasonable (UCR) charges for this region. I understand that there will be an additional fee of $25 for any "non-sufficient funds" checks presented to our office for payment upon my account.

I fully understand the agreement between this office and myself or my dependants. My signature below provides my authorization that I am responsible for the balance of my account for any professional services rendered.

X_____ _____/_____/_____
***Signature of* Patient (or parent if a minor)** **Date**

A. COMPLAINTS/CONCERNS

1. Please list your main health objectives or chief complaints. _____

When did you first notice this? _____ Have you ever experienced it before? **Yes / No**

In total, have you had this pain for more than 30 days in the past year? **Yes / No**

Describe what the condition feels like_____ What do you do for relief?

_____

Did something happen?_____

_____

2. When are your symptoms worse? ☐Morning ☐Afternoon ☐Evening ☐Night ☐Always the same

3. How did your complaint(s) begin? ☐Unknown ☐Suddenly ☐Gradually

4. Check all the appropriate descriptions.

The sensations I feel are:

Pain	Numbness	Tingling	Stiffness	Soreness	Swelling
☐	☐	☐	☐	☐	☐

The quality of the pain is:

Burning	Dull	Sharp	Shooting	Aching	Throbbing
☐	☐	☐	☐	☐	☐

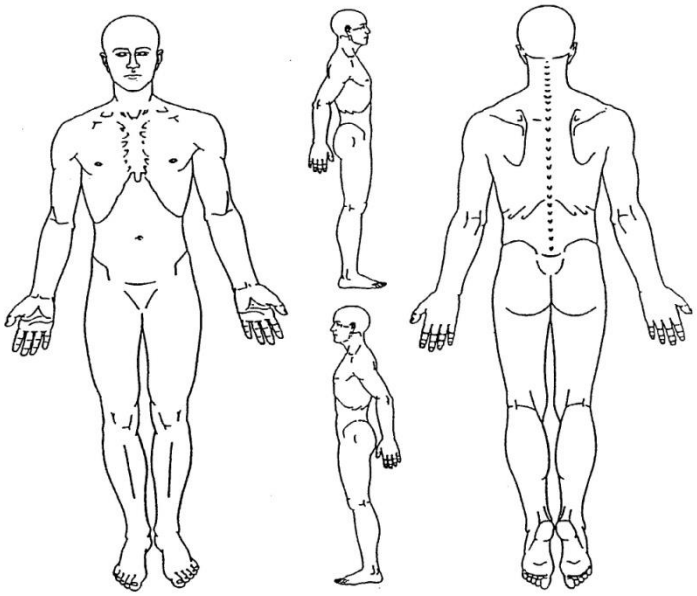
The pain duration is:

Occasional	Intermittent	Frequent	Constant
☐	☐	☐	☐

My condition is:

Improving	Worsening	Unchanged	Resolved
☐	☐	☐	☐

5. Indicate on the diagram where you have your complaints.



6. Mark what makes your condition Better or Worse?

☐B ☐W	☐B ☐W	☐B ☐W
☐ ☐ Bending	☐ ☐ Looking Down	☐ ☐ Rest
☐ ☐ Exercise	☐ ☐ Lying Down	☐ ☐ Sitting
☐ ☐ Heat	☐ ☐ Medication	☐ ☐ Standing
☐ ☐ Ice	☐ ☐ Nothing	☐ ☐ Stretching
☐ ☐ Lifting	☐ ☐ Pull/Pushing	☐ ☐ Twisting
☐ ☐ Looking Up	☐ ☐ Reaching	☐ ☐ Walking
☐ **Laughing**	☐ **Coughing**	☐ **Straining At Stool**

7. Have you noticed a change in?

☐ Bowel Function ☐ Bladder Function ☐ Coordination
☐ Sexual Function ☐ Muscular Strength

8. On a scale of 0- 10 rate the severity of your pain today.

If your pain fluctuates please indicate approximately the % of time at each pain level. *Example* 0 1 2 ③ 4 5 6 7 ⑧ 9 10

							70%		30%		
	No Pain								Worst Pain Possible		
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

9. What happened to cause or re-aggravate your complaint(s)?

☐Cause Unknown ☐Auto Accident ☐Personal Injury
☐Work Injury ☐Home Accident ☐Sport Injury
☐Other – Describe: _____

10. Please circle all areas of previous or current complaints or injuries.

Neck	Uppr back	Mid Back	Low Back	Shoulder	Arm	Elbow	Forearm	Wrist
Hand/Finger	Buttock	Hip	Thigh	Knee	Leg/Calf	Ankle	Foot	Others:

11. Please underline all of the following symptoms you have had previously. Please circle all of the following conditions you have now.

Anxiety	Concussion	Heartburn	Nervousness
Abdominal Pain	Constipation (Excess)	Hernias	Numbness
Appetite Change	Diarrhea (Excess)	Impotence	Pins and Needles
Bed-Wetting	Difficulty Breathing	Incontinence	Poor Circulation
Black Tarry Stools	Difficulty Hearing	Insomnia	Ringing in Ears
Blurred Vision	Difficulty Swallowing	Irritability	Skin, Hair or Nail Changes
Breast Lumps or Pain	Double Vision	Light Sensitivity	Sinus Trouble
Bruise Easy	Dizziness	Loss of Balance	Swelling
Chills	Enlarged Glands	Loss of Bowel Control	Tension
Cold Feet	Face Flushed	Loss of Smell	Urination Painful/Frequent
Cold Hands	Fainting	Loss of Taste	Vomiting (Recent)
Cold Sweats	Fatigue (Recent)	Memory Loss	Weight Change
Concentration Loss	Fever (Recent)	Menstrual Discomfort	
Confusion	Frequent Illness	Mood Swings	

B. HEALTH HISTORY

1. Do you or an immediate family member have, or ever had a problem with one of the following systems?
Indicate Y= You F=Family member. Please also identify your relationship to the family member on the side. Circle the condition that best describes the past health condition and provide any other details.

(Y) **F** Example, (Example), Example Mother

Y F Circulation, Blood Pressure or Heart
Y F Arthritis or Orthopedic
Y F Lung or Breathing
Y F Digestive
Y F Kidney or Bladder
Y F Epilepsy or Neurological
Y F Anxiety, Depression, Stress or Psychological
Y F Allergies
Y F Cancer or Tumors
Y F Diabetes

Y F Blood, Bleeding, Anemia
Y F Osteoporosis, Fibromyalgia, Gout
Y F Liver, Gallbladder, Hepatitis
Y F Irritable Bowel, Ulcers, Acid Reflux
Y F Thyroid, Adrenal
Y F Stroke, Paralysis, Tremors
Y F Immune Deficiency, Lymph Nodes
Y F Autoimmune, Psoriasis, Multiple Sclerosis
Y F Infections, Polio, Rheumatic, Tuberculosis, HIV
Y F Reproductive, Venereal Disease

2. Circle Yes or No

Yes No Have you ever had any operations to date? Please list Sx below:

_____

Yes No Do you smoke? If yes approximately how many packs per day? _____
Yes No Do you drink alcohol? If yes approximately how many drinks per week? _____
Yes No Do you exercise? How often? _____ What activities? _____
Yes No Have you suffered any significant injury as a result of an accident? Please Describe:

_____

For this set of questions, please think about your back pain over the past two weeks.

3. Overall, how bothersome has your back pain been in the last 2 weeks?

Not at all **Slightly** **Moderately** **Very much** **Extremely**

4. For each of the following, please circle whether you agree or disagree with the statement, thinking about the last 2 weeks

Disagree /Agree My back pain has spread down my leg(s) at some time in the last 2 weeks
Disagree /Agree I have pain in the shoulder or neck at some time in the last 2 weeks
Disagree /Agree I have only walked short distances because of my back pain
Disagree /Agree In the last 2 weeks, I have dressed more slowly than usual because of my back pain
Disagree /Agree It's really not safe for a person with a condition like mine to be physically active
Disagree /Agree Worrying thoughts have been going through my mind a lot of the time
Disagree /Agree I feel that my back pain is terrible and it's never going to get any better
Disagree /Agree In general I have not enjoyed all the things I used to enjoy

5. Indicate for each of the statements which number best describes your pain/complaint and how it has affected you over the past few days: 0 is 'no pain'10 is 'worst pain possible'

Over the past few days, on average, how would you rate your pain/complaint?
0 1 2 3 4 5 6 7 8 9 10
Over the past few days, on average, how has your pain/complaint interfered with your daily activities (housework, washing, dressing, and sleeping)?
0 1 2 3 4 5 6 7 8 9 10
Over the past few days, on average, how has your pain/complaint interfered with your normal social routine including recreational, social and family activities?
0 1 2 3 4 5 6 7 8 9 10
Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling?
0 1 2 3 4 5 6 7 8 9 10
Over the past few days, on average, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling?
0 1 2 3 4 5 6 7 8 9 10
Over the past few days, on average, how do you think your work (both inside the home and/or employed work) have affected your pain/complaint?
0 1 2 3 4 5 6 7 8 9 10
Over the past few days, on average, how have you been able to control (help/reduce) and cope with your pain/complaint on your own?
0 1 2 3 4 5 6 7 8 9 10
Additional Information
Please use this space to provide more information about your answers or anything you feel may be helpful for us to know:
_____
_____

6. Have you ever been to a chiropractor? Yes / No
Name _____

7. Family Physician Information
Date of Last Exam _____
Physician's Name _____
Location ___

8. Have you ever been hospitalized? Yes / No
Date and reason for hospitalization: _____
_____

9. Have you ever had surgery? Yes / No
Date, surgery and results: _____
_____

10. Have you ever had a fractured bone?
☐Yes ☐No Please list:
_____

11. Please give date of last:
X-ray _____
Other Imaging _____

12. Have any of the following occurred recently?
☐Increased Work Stress ☐Anxiety ☐A Death
☐Divorce ☐Depression ☐Chronic Fatigue
☐Economic Stress ☐Job Change ☐Family Problems

13. Current Height: _____ Weight: _____

14. Have you ever used the following?
☐Birth Control Pills ☐Corticosteroids

15. Are you allergic to seafood or sulfa drugs? ☐Yes ☐No

16. Are you currently taking any vitamins, minerals, or herbs? (List)

_____

_____

17. Women Only
To your knowledge, are you pregnant? ☐Yes ☐No
If pregnant in the past were pregnancies normal?
☐Yes ☐No
Are you seeing an OB-GYN regularly? ☐Yes ☐No

C. OCCUPATIONAL/DAILY ACTIVITIES

1. Are you right or left handed? ☐Right ☐Left

2. In what position do you sleep?
☐Back ☐Side ☐Stomach

3. Job Type
☐Full Time ☐Part Time ☐Temporary
☐Self-Employed ☐Retired ☐Unemployed
☐ Student (Skip to Patient's Signature)

4. Manual Labor: ☐Light ☐Moderate ☐Heavy

5. During your work week, you work how many:
Hours /Day ⓪①②③④⑤⑥⑦⑧⑨⑩
Days/Week ⓪①②③④⑤⑥⑦⑧⑨⑩

6. How long have you worked in this job?

_____

7. Do your present complaints affect the number of hours worked each day? ☐Yes ☐No

8. What is your primary work position?
☐Seated ☐Standing ☐Other

9. What movements does your job require?
☐Bending ☐Turning ☐Stooping
☐Twisting ☐Walking ☐Repetitive Actions
☐Carrying Other:

10. Does your work include prolonged use?
☐Computer ☐Phone

11. Does your job involve lifting?
☐Never ☐Occasional ☐Frequent
☐Constant
How many pounds: _____

12. What is your stress level at work?
☐Minimal ☐Moderate ☐Extreme

13. Do work activities aggravate your complaints?
☐Yes ☐No If yes, how? _____

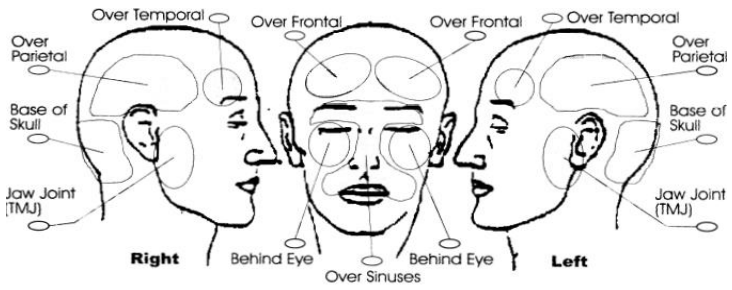
PATIENT'S SIGNATURE **DATE**

_____ _____

Essence of Wellness Chiropractic Center
890 South Barron Street, Eaton Ohio 45320
937-456-4555
EssenceOfWellness.com

HEADACHES – If you have headaches fill out this section

1. Where is the pain associated with your headaches?



2. On what date did your headaches begin?
Date: ___/___/___ ☐Same as Neck/Back complaints

3. What describes your pain?
☐Dull ☐Sharp ☐Deep ☐Burning
☐Aching ☐Stabbing ☐Vice-Like ☐Throbbing/Stabbing
☐Other:

4. When do your headaches usually start?
☐Constant/Anytime Awake ☐Wake up with in morning
☐At mid-day ☐During evening

5. Do your headaches wake you from sleep?
☐ No ☐Sometimes ☐Always

6. What seems to bring on your headaches?
☐Physical Activity ☐Caffeine ☐Excess stress
☐Certain Foods ☐Alcohol ☐Menstruation
☐Injury/Trauma ☐Other:

7. How often do your headaches occur?
☐ Days/Week: ⓪①②③④⑤⑥⑦
☐ Days/Month: ⓪①②③④⑤⑥⑦⑧⑨⑩ 15+
Chronic = 15+days for 3+months
Other: _____

8. How long do your headaches last?
☐Less than 1 hour ☐From 1-3 hours
☐Longer than 3 hours ☐All waking hours
☐Greater than 72 hours ☐Other

9. Do any of the following occur with your headaches?
☐Nausea/Vomiting ☐Weakness
☐Tremor ☐Vision Problems
☐Dizziness ☐Light/Sound Sensitivity
☐Aura ☐Other

10. What makes your headaches better?
☐Nothing (Intractable) ☐Rest
☐Lying down ☐Ice/cold packs
☐Massage ☐Standing
☐Prescription medication ☐Nonprescription medication
☐Other

11. Do your headaches make it difficult to?
☐Perform daily activities ☐Concentrate
☐Enjoy hobbies/sports ☐Read
☐Control your temper ☐Travel
☐Go out during daylight ☐Work
☐Other

Office Use Only
Migraine w/out Aura not Intractable >72hr G43.001 <72hr G43.009
Migraine w/out Aura Intractable >72hr G43.011 <72hr G43.019
Migraine Aura not Intractable >72hr G43.101 <72hr G43.109
Migraine Aura Intractable >72hr G43.111 <72hr G43.119
Migraine Chronic W/out Aura not Intractable >72hr G43.701 <72hr G43.709
Migraine Chronic W/out Aura Intractable >72hr G43.711 <72hr G43.719
Migraine Chronic Aura not Intractable >72hr G43.501 <72hr G43.509
Migraine Chronic Aura Intractable >72hr G43.511 <72hr G43.519
Tension Intractable G44.201 not Intractable G44.209
Episodic Tension Intractable G44.211 not Intractable G44.219
Chronic Tension Intractable G44.221 not Intractable G44.229
Post-traumatic unspecified Intractable G44.301 not Intractable G44.309