***Remember to bring completed paperwork: (If paperwork is not completed, arrive 30 min prior to appt.)**

First Name: _____ MI: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip:_____

Gender: ___M ___F ___Trans Age: _____ DOB: _____ Marital Status: __S __M __W __D __P

Cell Phone: _____ Cell phone carrier (for appt text reminders):_____

E-mail: _____ Occupation/Employer: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Primary Care Doctor: _____ Who may we thank for your referral? _____

PRIMARY INSURED INFORMATION

If you are the primary insured, mark "self" and move down to "Payment Information".

Primary insured: □ Self □ Spouse □ Parent □ Other: _____

First Name: _____ MI: _____ Last Name: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Gender: □M □F DOB: _____Cell Phone: _____ E-mail: _____

PAYMENT INFORMATION

Please check the following payment methods that apply: □ Cash (Time of Service) □ Health Insurance □ Workers Compensation □ Auto Insurance (auto injury) Date of auto injury/accident: _____

SYMPTOM SURVEY

1. What is your ***Primary*** complaint? _____
2. Was there trauma or a known cause? □YES □NO

   If yes, describe: _____.

3. When did your symptoms begin? _____
4. How often do the symptoms bother you?

   □ Constant □ Frequent □ Intermittent □ Occasional

5. Has this condition bothered you before? □YES □NO
6. Would you describe it as (circle all that apply): **SHARP, SHOOTING, ACHY, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBBING, NUMBNESS, TINGLING, CRAMPING, OTHER:** _____

7. How severe is you pain/discomfort from **0 (*none*) to 10 (*worst imaginable*)**?

_____

8. What makes it worse? _____What relieves it? _____
9. Any other symptoms associated with this complaint?

_____

10. Treated for this in the past? □YES □NO When?_____Where?

_____

Problem #2 _____ Was there trauma or a known cause? □YES □NO

If yes, describe: _____

When did your symptoms begin? _____

How often do the symptoms bother you? □ Constant □ Frequent □ Intermittent □ Occasional

Has this condition bothered you before? □YES □NO

Would you describe it as (circle all that apply): **SHARP, SHOOTING, ACHY, ELECTRICAL, DEEP, DULL, ACHING, STIFF,**

THROBBING, NUMBNESS, TINGLING, CRAMPING, OTHER

_____

Where is you pain/discomfort from 0 (*none*) to 10 (*worst imaginable*)?

_____

What makes it worse? _____What relieves it? _____

Any other symptoms associated with this complaint?

_____

Treated for this in the past? □YES □NO When?_____Where?

_____

Problem #3 _____ **Problem #4**

_____

Special Imaging and/or Tests (MRI, CT, X-Ray, etc):

Year: _____ Test: _____ Findings:

_____

Year: _____ Test: _____ Findings:

_____

Year: _____ Test: _____ Findings: _____

Other:_____

___ MEDICAL HISTORY

Past or Present Concerns:

__ Arthritis
__ Allergies/Hay Fever/Asthma
__ Alcoholism
__ Alzheimer's/Dementia
__ Autoimmune _____
__ Blood Pressure problems
__ Bronchitis
__ Cancer_____
__ Carpal Tunnel Syndrome
__ Celiac Disease
__ Chronic Fatigue Syndrome
__ Cholesterol, High
__ Circulatory Problems
__ Colitis
__ Contact Lenses
__ Dental problems
__ Depression

Medical (Men)
__ Benign Prostatic Hyperplasia
__ Prostate Cancer
__ Decreased Sex Drive
__ Infertility
__ Sexually Transmitted Disease
__ OTHER_____

Medical (Women)
__ Menstrual Irregularities
__ Endometriosis
__ Infertility
__ Fibrocystic Breasts
__ Fibroids/Ovarian Cysts
__ Premenstrual Syndrome
__ Pelvic Inflammatory Disease
__ Vaginal Infections
__ Decreased Sex Drive
__ C-Section
__ Menopause
__ Breast Cancer

Family Health History- Parents/Grandparents/Siblings:

__ Autoimmune
__ Arthritis
__ Alcoholism
__ Alzheimer's/Dementia
__ Celiac Disease
__ Migraine Headaches
__ Eating Disorder_____
__ Genetic Disorder
__ Glaucoma
__ Heart Disease
__ Cancer _____
__ Neurological Disorders_____
__ Obesity
__ Osteoporosis
__ Stroke
__ Mental Illness
__ Diabetes

Do you have a **Primary Care Provider?** □YES □NO

When was your **Last Physical**?_____

MSQ -MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

Name: _____ Date: _____**Height**_____

Weight_____

Point	**0** - Never or almost never have the symptom	**3** - Frequently have it, effect is not severe

Scale	**1** - Occasionally have it, effect is not severe		**4** - Frequently have it, effect is severe
	2 - Occasionally have it, effect is severe		
Head	____ Headaches	**Digestive**	____ Nausea, vomiting
	____ Faintness	**Tract**	____ Diarrhea
	____ Dizziness		____ Constipation
	____ Insomnia		____ Bloated feeling
	____ **TOTAL**		____ Belching, passing gas
Eyes	____ Watery or itchy eyes		____ Heartburn
	____ Swollen, reddened or sticky eyelids		____ Intestinal/stomach pain
	____ Bag or dark circles under eyes		____ **TOTAL**
	____ Blurred or tunnel vision	**Joints/**	____ Pain or aches in joints
	(does not include near or far-sidedness)	**Muscle**	____ Arthritis
	____ **TOTAL**		____ Stiffness or limitation of movement
Ears	____ Itchy Ears		____ Pain or aches in muscles
	____ Earaches, ear infections		____ Feeling of weakness or tiredness
	____ Drainage from ear		____ **TOTAL**
	____ Ringing in ears, hearing loss	**Weight**	____ Binge eating/drinking
	____ **TOTAL**		____ Craving certain foods
Nose	____ Stuffy Nose		____ Excessive weight
	____ Sinus problems		____ Compulsive eating
	____ Hay fever		____ Water retention
	____ Sneezing attacks		____ Underweight
	____ Excessive mucus formation		____ **TOTAL**
	____ **TOTAL**	**Energy/**	____ Fatigue, sluggishness
Mouth/	____ Chronic coughing	**Activity**	____ Apathy, lethargy
Throat	____ Gagging, frequent need to clear throat		____ Hyperactivity
	____ Sore throat, hoarseness, loss of voice		____ Restlessness
	____ Swollen or discolored tongue/gums/lips		____ **TOTAL**
	____ Canker sores	**Mind**	____ Poor memory
	____ **TOTAL**		____ Confusion, poor comprehension
Skin	____ Acne		____ Poor concentration
	____ Hives, rashes, dry skin		____ Difficulty in making decisions
	____ Hair loss		____ Stuttering or stammering
	____ Flushing, hot flashes		____ Slurred speech
	____ Excessive sweating		____ Learning disabilities
	_____ **TOTAL**		____ **TOTAL**
Heart	____ Irregular or skipped heartbeat	**Emotions**	____ Mood swings
	____ Rapid or pounding heartbeat		____ Anxiety, fear, nervousness
	____ Chest pain		____ Anger, irritability, aggressiveness
	____ **TOTAL**		____ Depression
Lungs	____ Chest congestion		____ **TOTAL**
	____ Asthma, bronchitis		**<10 – Optimal 10-50 – Mild Toxicity**
	____ Shortness of breath		**50 – 100 Moderate Toxicity >100 – Severe Toxicity**
	____ Difficulty breathing		
	____ **TOTAL**		**GRAND TOTAL: _____**

INTERESTS AND GOALS

To allow us to better address your healthcare goals & priorities, please check what applies to you and your interests.

What types of care are you open to?

___ **Chiropractic/Sports Medicine:** This approach involves addressing musculoskeletal and neurological function through addressing postural or biomechanical imbalances. Injury treatment and prevention are often achieved through joint manipulation, active and passive stretching, soft tissue techniques, traction, physical therapy modalities, and therapeutic home exercise programs.

___ **Therapeutic Massage:** Several forms of deep tissue massage and other forms of body work are offered. Our licensed massage therapists offer targeted treatments for athletes, work and auto injuries, postural stress, and even pregnancy massage.

___ **Functional Medicine:** Upstream approach to getting to the root cause of many chronic conditions and health concerns including gastrointestinal dysfunction, autoimmune conditions, chronic fatigue, weight gain, mood disorders, cardiovascular health, and skin complaints. Specialty lab testing, supplements, dietary intervention and lifestyle modifications are the most commonly utilized methods with this approach to best address gut function, sensitivities, toxic burdens, hormone and immune function, and inflammation.

___ **Nutrition:** Professional guidance with meal planning, shopping, and determining the best diet for an individual's specific needs or specific condition. Areas of focus include: weight management, athletic performance, food sensitivities/allergies, Celiac and IBD, cancer, and digestive health.

___ **Infrared Sauna:** We offer the highest quality Full Spectrum Infrared Sauna therapy with our Sunlighten Sauna. Some of the many benefits include: Detoxification, Weight Loss, Pain Relief, Anti-Aging, Immune Enhancement, Relaxation, Cardiovascular and Skin Health.

___ **Pulsed Electromagnetic Field (PEMF) Therapy:** Through improving the cell membrane potential via charging the cells of the body, improved circulation, oxygen uptake, mitochondrial function, nutrient uptake, and elimination of cellular waste, this modality proves to be quite an impressive therapy. Recommended for improving athletic performance/recovery, strains/sprains/broken bones, post-surgery, neurological complaints, concussions, and in conjunction with Functional Medicine.

Specific Health Goals:

__ Have More Energy	__ Improve Strength	_ _ Improve Concentration
__ Sleep Better	__ Improve Flexibility	__ Improve Memory
__ Be Free of Pain	__ Improve Balance	__ Neurological Support
__ Improve Immunity	__ Reduce Weight	_ _ Reduce Depression
__ Heart Health	__Sport Specific _____	__ Reduce Stress

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

The Nature of Chiropractic Manipulation: The doctor will often use his/her hands or a mechanical device in

order to move your joints. You may feel a “click” or a “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, soft tissue therapies, corrective exercises, or active stretching may also be utilized.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular incident could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burn, or minor complications.

Other Treatment Options: May include over-the-counter analgesics, prescription medications, injections, and surgery.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

No Warranty: I understand that my doctor at Wellness Doctor, cannot make any promises or guarantees regarding a cure for or improvement of my condition. I understand that my doctor will share with me his/her opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment options with me before I consent to treatment.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Printed Name: _____Signature: _____Date: _____

Consent To Treat A Minor

I hereby authorize Wellness Doctor to administer Chiropractic care, as deemed necessary, to my child.

Name of Child: _____ Age: _____ Date: _____

Parent /Guardian Signature: _____

Financial Policy

To ensure your treatments are as stress free as possible we have established a clear financial policy.

Please read and initial next to the policy that applies to you. If you have any questions don’t hesitate to ask!

Insurance: We will bill your insurance as a courtesy for you. If you provide us with your current insurance information we will do our best to verify your benefits prior to receiving care, however insurance companies will never allow a quote of coverage to be a guarantee of payment. We will collect 100% of services not covered by your insurance carrier. If you have a copay, co-insurance, or unmet deductible you will be responsible for payment at time of service. **We do offer services that may not be covered by your insurance and you will be responsible for the balance.** Please be aware that some patient's policies are written to where they may have a deductible for certain services and or a copay for certain services. ***Insurance is a contract between the patient and their carrier, so it is important that you take responsibility for understanding your benefits. ***

Auto Accident/Personal Injury/Workman's Compensation: Most Personal Injury and Workman's Compensation claims are covered 100%. However, it is **YOUR** responsibility to provide our office with the documentation necessary to prove a valid claim which includes your claim number, as well as the name(s) of any claims adjustor/attorney, etc. handling the case, their phone and fax number and the mailing address to send bills. Failing to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due on receipt. We can send any unpaid claims to your personal health insurance if it was in effect during your treatment as long as you provide us with current insurance information. If you miss more than two appointments and do not call within the 24-hr. cancellation period, appointments with our facility may be terminated.

Cash: Payment is due at the time of service. A prompt pay incentive discount is offered for patients that do not have insurance or choose to not use their insurance. Please speak with our front desk staff to go over those prices.

*Unpaid balances greater than 120 days will be sent to collections and you will be charged an additional 35% to cover the cost of collections (this amount will be added to you bill). *

I have read and understand the above Financial Policy.

Signature of Patient or Responsible Party **Date**

HIPAA Acknowledgement of Notice of Privacy Practices

PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

*My health information may be created or received by Wellness Doctor, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

*We may use health information about you to provide you with medical treatment of services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of

you and your health.

*I understand that I have the right to receive and review a written description of how Wellness Doctor, LLC will handle my health information. This written description is known as a NOTICE OF PRIVACY PRACTICES and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Wellness Doctor, LLC and my rights regarding my health information.

*I understand that the NOTICE OF PRIVACY PRACTICES may be revised periodically. We will not disclose your health information unless we have received written consent. I understand that a copy of summary of the most recent version of Wellness Doctor, LLC's NOTICE OF PRIVACY PRACTICES in effect will be posted in the waiting/reception area.

Special Permission Request:

I give my permission for Wellness Doctor, LLC to leave messages regarding appointments on my home/cell phone answering machine.

Initial:

Date:

I give my permission to speak with/leave messages regarding treatment, billing and regarding appointment status left with my spouse, partner, caregiver.

Initial:

Date:

Name:

By signing this agreement, I attest that I understand the information above. Our posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this policy before signing this consent. This release will revoke by written permission only.

I understand that I must send a written request to Wellness Doctor, LLC to revoke this release.

Signature: _____ Date: _____

MASSAGE PATIENT WAIVER FORM

Please read and initial the following information if you think you would like/need massage at our clinic.

___ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular and fascial tension, improvement of circulation and energy flow.

___ If I experience pain or discomfort during the session, I will immediately inform the Licensed Massage Therapist (LMT) so that pressure/strokes can be adjusted to my level of comfort. I will not hold Wellness Doctor or the LMT responsible for any pain or discomfort I experience during or after the session.

___ I understand that the services offered today are not a substitute for medical care. I understand that the LMT, is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

___ I affirm that I have notified the LMT of all known medical conditions, medications, and injuries.

___ I agree to inform the LMT of any changes in my health and medical condition (ex. pregnancy). I understand that there shall be no liability on the LMT should I forget to do so.

___ By signing this release, I hereby waive and release Wellness Doctor and the LMT from all liability, past, present, and future relating to massage therapy and bodywork.

_____ _____

Patient Signature Date