wellfit
CHIROPRACTIC

General Information

Patient name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Phone: _____ ☐ Cell ☐ Home

Are you a veteran or active duty? ☐ Yes ☐ No

Date of Birth: _____

Occupation: _____

Employer: _____

How did you hear about/find us? _____

Is this your first visit to a Doctor of Chiropractic?

☐ No ☐ Yes

Emergency Contact Information

Name: _____

Relationship: _____

Phone: _____ ☐ Cell ☐ Home

Doctor's Notes

Reason for Visit

Primary area of concern: _____

Secondary area(s): _____

Have you received treatment for this condition in the past? ☐ No ☐ Yes

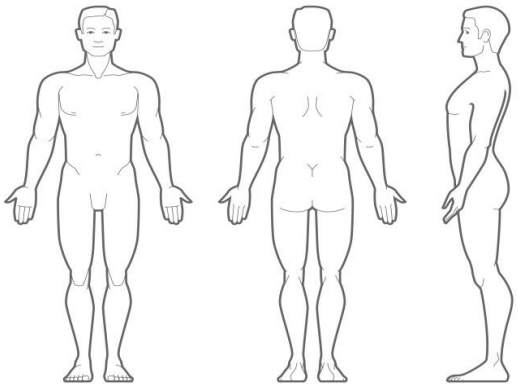
If yes, when & where? _____

Are you seeking treatment related to an accident?

☐ Auto ☐ Work ☐ Personal ☐ Other

Using the symbols below, please mark any areas where you're experiencing pain:

× Pain ⊘ Numbness or Tingling # Burning



How severe is your pain on a scale of 0 to 10?

On Average: _____ At Worst: _____ At Best: _____

What % of the day do you feel this discomfort? _____

Check the boxes that best describe your symptoms:

☐ Constant ☐ Comes & goes
☐ Worse at night ☐ Worse in the morning
☐ Sharp ☐ Aching ☐ Shooting
☐ Throbbing ☐ Dull ☐ Other: _____

When did your symptoms first appear?

_____

What (if anything) makes it better?

_____

What makes it worse or irritates it?

_____

Health History

Recent signs & symptoms: (Please check all that apply.)

- ☐ Constant Pain
- ☐ Unexplained Weight Loss/Gain
- ☐ Severe or Frequent Headaches
- ☐ Abdominal Bleeding/Pain
- ☐ Fatigue
- ☐ Excessive Thirst
- ☐ Frequent Painful Urination
- ☐ Excessive Bruising
- ☐ Dizziness
- ☐ Nausea/Vomiting
- ☐ Blood in Urine
- ☐ Difficulty Breathing
- ☐ Change in Appetite
- ☐ Numbness
- ☐ Black/Bloody Stools
- ☐ Tightness in Chest
- ☐ Loss of Sleep
- ☐ Loss of Bladder Control

Have you ever had any of the following conditions?

- ☐ Cancer/Chemotherapy
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Bruise Easily
- ☐ Clotting Disorder
- ☐ Cardiovascular Disease
- ☐ Heart Attack
- ☐ Hypertension
- ☐ Pacemaker/Heart Surgery
- ☐ Stroke
- ☐ Swelling in Ankles/Legs
- ☐ Allergies
- ☐ Glaucoma
- ☐ Recurring Ear Infections
- ☐ Recurring Sinusitis
- ☐ Digestive Problems
- ☐ Belching/Gas/Bloating
- ☐ Kidney Disease
- ☐ Anxiety
- ☐ Depression
- ☐ Drug/Alcohol Dependency
- ☐ Disc Herniation/Bulge
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Latex Allergy
- ☐ Psoriasis
- ☐ Sprained Ankle
- ☐ Pain Between Shoulders
- ☐ Thyroid Problems

Please list any major injuries, hospitalizations, surgeries, or serious illnesses, with approximate dates: (broken bones, caesarian section, appendicitis, cancer, etc.)

_____

_____

_____

_____

Medications

- ☐ Cholesterol Medications
- ☐ Stimulants
- ☐ Tranquilizers
- ☐ Muscle Relaxers
- ☐ Anxiety
- ☐ Insulin
- ☐ Blood Pressure Medication
- ☐ Blood Thinners
- ☐ Pain Killers (including Aspirin)
- ☐ Other: _____

Allergies:

_____

_____

_____

_____

_____

Lifestyle

Exercise

- ☐ None
- ☐ Minimal
- ☐ Moderate
- ☐ Daily
- ☐ Excessive

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Medium Labor
- ☐ Heavy Labor

Habits

- ☐ Smoking Frequency: _____
- ☐ Alcohol Frequency: _____
- ☐ Recreational Drugs Type: _____
- ☐ Coffee/caffeine Frequency: _____
- ☐ High Stress Reason: _____

Nutrition

How would you describe your eating habits?

- ☐ I eat whatever and whenever I want.
- ☐ I make an attempt to eat right, but struggle.
- ☐ Most of the time I eat right, but treat myself on occasion
- ☐ I strictly regulate my food intake, all the time.
- ☐ I'm all over the board. No consistency

Sleeping

Average hours of sleep per night? _____

I normally sleep on my:

☐ Back ☐ Stomach ☐ Side ☐ Toss & Turn

Do you feel rested when you wake up?

☐ Yes ☐ No

Vitamins: _____

_____

_____

_____

Women

Are you currently pregnant?

☐ No ☐ Yes, Due Date: _____

- ☐ Birth Control
- ☐ Painful Periods
- ☐ Nursing
- ☐ Irregular Cycles

Family History

_____

_____

_____

Treatment Goals

- ☐ Corrective Care
- ☐ Relief of Symptoms
- ☐ Wellness Care
- ☐ Other: _____
- ☐ Decrease Pain
- ☐ Pain Management
- ☐ Preventative Care
- ☐ Return to Pre-Injury Status
- ☐ Increased Overall Wellness
- ☐ Look and Feel Better

On a scale of 1-10, with 10 being the highest, please rate your commitment in helping us solve this problem: _____

Authorization to Provide Care

I authorize the physicians at WellFit Chiropractic to administer care or treatment as they deem appropriate, for the purpose of regaining and/or maintaining musculoskeletal health, unless I expressly refuse beforehand.

Sign: _____ Date: _____

Receipt of Notice of Privacy Practices

I have been offered a copy of WellFit Chiropractic's Notice of Privacy Practices, which provides an explanation of my rights with respect to my personal health information and the privacy practices of this clinic, in accordance with the Health Insurance Portability & Accountability Act (HIPAA) of 1996. I understand I can review this notice anytime at www.wellfitmn.com

Sign: _____ Date: _____

Fees and Financial Policy

Our focus is your health; we provide this information regarding our fees and financial policies to avoid surprises or misunderstandings when providing payment, so that we can direct all our attention towards getting you better. Payment for services rendered is due on the date of service and accepted in the forms of cash, check, charge (HAS or Flex-Spend is the best). Patients may choose to submit a reimbursement claim directly to their insurance provider. WellFit Chiropractic will supply the necessary documentation for this purpose, upon request.

Consult	No Charge
New Patient Visit (includes adjustment)	$100
Chiropractic Adjustment	$49
Chiropractic Adjustment (12 & under)	$25
Whole Family (adjustment only)	$130