WellnessOne
It's your future...be there healthy with WellnessOne.™

Confidential Patient Information

Date: _____

Last Name: _____ First Name: _____ Initial: _____

Major Complaint Information

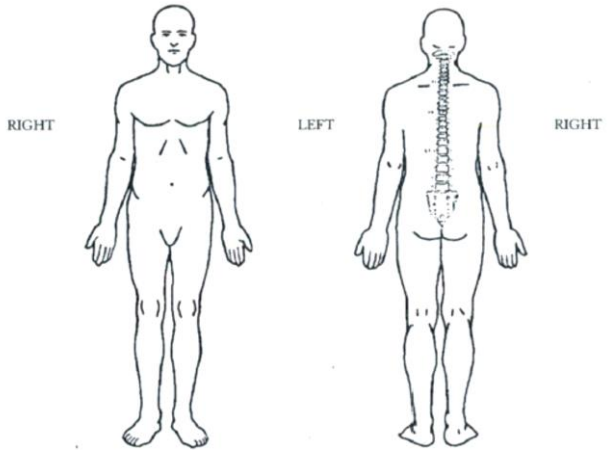
What is your current complaint? _____

_____

Breifly describe your symptoms. _____

_____

Using the symbols in the Pain Index, mark the areas where you're experiencing pain, followed by a number from 1-10 indicating the extent of the pain. (1 being minor, 10 being severe)



Pain Index

D Dull Nagging Ache

B Burning

S Sharp/Stabbing

N Numbness/Tingling

M Muscle Spasms/Pulling

For example if you are experiencing moderately severe burning pain in back of your neck, you should note a "B8" on the neck of the illustration

On a scale of 1-10, how do you feel now? (1 being best, 10 being the worst)

1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? Yes/No When? _____

What aggravates this condition? _____

What decrease the symptoms/pain? _____

Does heat affect the pain? Yes/No If so, how? _____

Does cold affect the pain? Yes/No If so, how? _____

Have you seen another doctor for this condition? Yes/No Doctor's Name: _____

Date Consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? Yes/No

If so, how many times do you wake up in pain per night? _____

In what position do you sleep? Back/Side/Stomach

Do you sleep with a pillow? Yes/No How many? _____

Do you wear a heel lift? Yes/No If so,which side? Right/Left

Does it cause pain to cough, grunt or sneeze? Yes/No If so, where? _____

Check those activities bellow during which you experience difficulty or pain:

☐ Lying on back	☐ Getting in/out of car	☐ Pulling	☐ Sitting	☐ Dressing self
☐ Lying on side	☐ Standing for long periods	☐ Reaching	☐ Bending forward	☐ Sneezing
☐ Turning over in bed	☐ Sexual Activity	☐ Kneeling	☐ Bending backward	☐ Coughing
☐ Pushing	☐ Lying flat on stomach	☐ Stooping	☐ Walking	☐ Other _____

Lower Back Pain

Does pain radiate into the leg? ☐ Yes ☐ No Does pain radiate to the abdomen? ☐ Yes ☐ No

Do you ever have impairment of bowel or urinary function? ☐ Yes ☐ No Explain: _____

Do you ever have numbness or tingling into the legs? ☐ Yes ☐ No Explain: _____

Neck Pain

If you have a neck injury, does it affect: (check all that apply) ☐ Hearing ☐ Vision ☐ Balance ☐ Cause ringing in your ears

Do you hear grating sounds? ☐ Yes ☐ No Do you feel pressure or pain behind your eyes? ☐ Yes ☐ No

Does pain radiate into the arm? ☐ Yes ☐ No Explain: _____

Do you have difficulty lifting or turning your head? ☐ Yes ☐ No If so, in which direction? ☐ Right ☐ Left ☐ Up ☐ Down

Headaches

Do you get headaches? ☐ Yes ☐ No Frequency_____ Do you have a family history of headaches? ☐ Yes ☐ No

Do you experience the following along with headaches: Pain or cracking in your jaw? ☐ Yes ☐ No

Abnormal blood pressure? ☐ Yes ☐ No ☐ High ☐ Low Nausea, Vomiting or Visual disturbances? ☐ Yes ☐ No

When was your last eye exam by a doctor? _____ Results: _____

If female, are you pregnant? ☐ Yes ☐ No ☐ Not Sure If yes, what is your due date:_____

List all medications you are taking now, including over the counter medications and vitamins. _____

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No ☐ Not Sure Please list: _____

Have you ever had any surgeries or hospitalizations? ☐ Yes ☐ No

If yes, please list any within the last year and any that pertain to your current complaint:

Type of Hospitalization/Surgery Date

_____

_____

_____

Have you been x-rayed in the last 12 months? ☐ Yes ☐ No When? _____

Have you ever been seen by a chiropractor before? ☐ Yes ☐ No Please List:

Name of Chiropractor Date

_____

Do you have a family physician? ☐ Yes ☐ No Name of Physician: _____

Phone: _____ Address:_____

City/State/Zip: _____

Additional Complaints

Please circle all additional complaints that you have currently:

Loss of Concentration	Neck Stiffness	Shortness of Breath	Cold Hands	Arthritis
Eyes Sensitive to Light	Neck Motion Restricted	Irritable	Cold Feet	HIV (Aids)
Memory Loss	Upper Back Pain/Stiffness	Anxiety	Jaw Pain	Cancer
Heavy Feeling of Head	Mid Back Pain/Stiffness	Insomnia	Hypertension	Other: Please List
Dizziness	Right/Left Shoulder Pain	Depression	Diabetes	_____
Ringing in Ears	Right/Left Arm Pain	Fatigue	Convulsions	_____
Loss of Balance	Pins & Needles Arms/Legs	Excess Perspiration		_____
Loss of Smell	Right/Left Leg Pain	Digestive Trouble	Allergies: Please List	
Loss of Taste	Chest Pain	Nausea	_____	
Pain behind Eyes	Sinus Trouble	Please Specify Location:	_____	
Fainting	Nervousness	Numbness _____		
Anemia	Palpitation	Swelling _____		
Constipation	Heart Disease	Cuts _____		
Vomiting	Diarrhea	Bruising _____		

Do you have, or have you ever had, any diseases or medical problems not listed? If so, please list: _____

_____

Any additional information you would like the doctor to know before beginning care at WellnessOne: _____

_____

Personal Information

Address: _____

City / State / Zip: _____

Cell Phone:_____ Cell Phone Carrier:_____

E-mail: _____ Birth Date:_____ Sex: ☐Male ☐Female

Occupation: _____ Employers Name: _____

Marital Status: ☐S ☐M ☐D ☐W Spouse's Name: _____ Number of Children: _____

How were you referred to WellnessOne? _____

Emergency Contact

Name: _____ Relation: _____

Phone: _____ Address: _____

City / State / Zip: _____

Health Insurance Information

Insurance Company: _____ Phone#: _____

Policy Holder's Name: _____ Policy Holder's Birth Date: _____

Policy #: _____ Group #: _____

Before We Begin Care

WellnessOne would like to know before we begin care, what are you looking to accomplish? We want you and the doctor to be on the same page regarding your care. Please choose from the following options:

- ☐ I just want relief from my pain, but I do not want the problem corrected.
- ☐ I want my problem corrected.
- ☐ I want my problem corrected and to be educated on ways to stabilize/maintain my overall health.

Authorization & Assignment

I authorize WellnessOne to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned, do hereby appoint WellnessOne authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Informed Consent

I hereby authorize physicians and staff at WellnessOne to treat my condition as deemed appropriate. The doctor will be not held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of WellnessOne responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness: Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury: Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.

Rib Injury: Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is preformed carefully to minimize such risk.

Physical Therapy Burns: Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke: Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems: There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date: _____ Patient's Signature: _____ Witness: _____

WellnessOne
It's your future...be there healthy with WellnessOne.™

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____ , 20_____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

Dated this _____ day of _____ , 20_____

By_____
Signature of Parent/Guardian (circle one)

WellnessOne Chiropractic
2621 South 70th Street, Suite A
Lincoln, NE 68506
P: 402-484-0200
F: 402-484-5677
WellnessOneNebraska.com