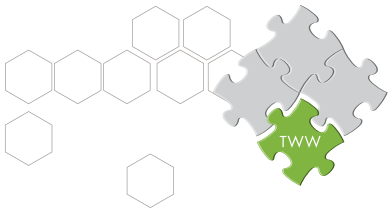

THE WELLNESS WAY

The Wellness Way - Eau Claire
4410 Golf Terrace, Suite 120, Eau Claire, WI 54701
thewellnessway.com

Patient Information:

Date _____ SSN _____ Birthday _____

First Name _____ Middle Name _____ Last Name _____

Gender _____ Height _____ Weight _____

Married/Civil Union _____ Spouse Name _____ # of Children _____

Home # _____ Cell # _____ Work # _____

Address _____

City _____ State _____ Zip _____

Emergency Contact _____ Emergency Relation _____ Emergency # _____

Patient Email _____

Employment Information:

Employed ○ Yes ○ No Employer Name _____

Employer Address _____

Employer City _____ Employer State _____ Employer Zip _____

Occupation _____ Work Supervisor _____ Supervisor # _____

Work Duties _____

Insurance Information:

Insurance Name _____ Primary Phone _____ Primary ID/Policy _____

Primary Address _____

Primary City _____ Primary State _____ Primary Zip _____

Primary Group # _____ Primary Name _____ Primary DOB _____

Personal Health History:

Last Physical Exam _____ Primary Physician _____ Physician Phone _____

Physician City _____ Physician State _____ Physician Zip _____

Health Conditions _____

Previous Chiro Care ○ Yes ○ No Date of Last Adjustment _____ Reason _____

Current Medications _____

_____

Current Supplements _____

_____

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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 _____

Has this concern occurred before? ○ Yes ○ No

Briefly Explain _____

Have you seen other doctors for this concern? ○ Yes ○ No

Type of treatment _____

Complaint Information:

Injury Occurred? If yes, complete the following: ○ Work ○ Automobile ○ Third-Party ○ Other Injury Date _____

Injury Origin _____

Describe Discomfort _____

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 _____

Aggravates Condition _____

Improves Condition _____

Received Treatment ○ Yes ○ No Explain _____

X-rays Taken ○ Yes ○ No Explain _____

Pain Level Rating - Scale 1-10 At its best _____ At its worst _____ Current Level _____

Same Condition as Before ○ Yes ○ No Date _____ Practitioner _____

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For Women Only:

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 _____

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

Age of first period _____

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? _____

Patient Social:

Alcohol	○ Daily ○ Weekly ○ Occasionally ○ Never	Caffeine	○ Daily ○ Weekly ○ Occasionally ○ Never
Diet Food Products	○ Daily ○ Weekly ○ Occasionally ○ Never	Drugs	○ Daily ○ Weekly ○ Occasionally ○ Never
OTC Stimulants	○ Daily ○ Weekly ○ Occasionally ○ Never	Exercise	○ Daily ○ Weekly ○ Occasionally ○ Never
Homemade Food	○ Daily ○ Weekly ○ Occasionally ○ Never	Processed Food	○ Daily ○ Weekly ○ Occasionally ○ Never
Soft Drinks	○ Daily ○ Weekly ○ Occasionally ○ Never	Tobacco	○ Daily ○ Weekly ○ Occasionally ○ Never
Water	○ Daily ○ Weekly ○ Occasionally ○ Never		

Patient Incident History:

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 _____	

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Patient Health History:

- ○ Alcoholism
- ○ Arteriosclerosis
- ○ Autoimmune Disease: _____
- ○ Breast Lump
- ○ Cancer
- ○ Congestive Heart Failure
- ○ COPD/Emphysema
- ○ Dementia/Alzheimer's
- ○ Diagnosed Emotional/Mental
- ○ Epilepsy
- ○ Fatigue
- ○ Glaucoma
- ○ Hemorrhoids
- ○ Irregular Heart Beat
- ○ Kidney Stones
- ○ Loss of Memory
- ○ Lung Disease
- ○ Nosebleeds
- ○ Polio
- ○ Retinal Disease
- ○ Shortness of Breath
- ○ Sleep Problems/Insomnia
- ○ Stroke
- ○ Thyroid Condition
- ○ Other: _____
- ○ Allergies
- ○ Arthritis
- ○ Back Pain
- ○ Bronchitis
- ○ Cataracts
- ○ Cold Extremities
- ○ Cramps
- ○ Depression
- ○ Digestion Problems
- ○ Excessive Menstruation
- ○ Frequent Urination
- ○ Gout
- ○ Hot Flashes
- ○ Irregular Menstrual Cycle
- ○ Liver Disease/Cirrhosis
- ○ Loss of Smell
- ○ Macular Degeneration
- ○ Pacemaker
- ○ Poor Posture
- ○ Sciatica
- ○ Sinus Infection
- ○ Smoker
- ○ Swelling of Ankles
- ○ Tuberculosis
- ○ Venereal Disease
- ○ Anemia
- ○ Asthma
- ○ Bleeding Disorders
- ○ Bruise Easily
- ○ Chest Pain
- ○ Constipation
- ○ CVA (stroke/Transient Ischemic Attack)
- ○ Diabetes
- ○ Dizziness
- ○ Eye Pain or Difficulties
- ○ Gallbladder Disease/Stones
- ○ Headache
- ○ Hormone Replacement
- ○ Kidney Infection
- ○ Loss of Balance
- ○ Loss of Taste
- ○ Migraines
- ○ Parkinson's
- ○ Prostate Trouble
- ○ Seizures
- ○ Skin Sensitivity
- ○ Spinal Curvatures
- ○ Swollen Joints
- ○ Ulcers
- ○ Varicose Veins

Do you have a history of any of the following? Please select all that apply.

- ○ Myocardial Infarction (Heart Attack)
- ○ Bypass Surgery
- ○ Hypertension
- ○ Coronary Artery Disease

Do you have Diabetes? If so, what type? ○ Type I ○ Type II ○ Juvenille

Do you have stomach/digestive issues? Please select all that apply. ○ Ulcers ○ Reflux ○ IBS

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How Did You Hear About Us:

Current TWW Patient? ○ Yes ○ No Patient Name: _____

Social Media ○ Yes ○ No Which platform? _____

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 treat my condition as the practitioners 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 72 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 _____