The Wellness Center

Patient Full Name : _____

Date : _____ Chart : _____

Have you consulted a Chiropractor before? ☐ No ☐ Yes

When? _____ If so, whom? _____

Whom may we thank for referring you? _____

Gender: ☐ Male ☐ Female Your Social Security Number _____

What name would you like us to address you by ? _____

Birth Day (MM/DD/YYYY) _____ Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address : _____ City: _____ State/Province: _____ ZIP/Postal Code: _____

Email Address _____ Cell Phone _____ Home Phone _____

Emergency Contact _____ Phone _____

Spouse's Name _____

Child's Name and Age _____ Child's Name and Age _____

Child's Name and Age _____ Child's Name and Age _____

May we contact you at work ☐ Yes ☐ No Preferred method of contact : ☐ Home ☐ Cell Phone ☐ Work Phone ☐ Email

Your Employer _____ Phone _____

Address : _____ City: _____ State/Province: _____ ZIP/Postal Code: _____

Insurance Carrier _____ Policy Number _____

Insured's Last Name _____ Birth Day (MM/DD/YYYY) _____

First Name _____ Middle Name (or initial) _____

Primary Care Provider's Name _____

Who carries this policy ? ☐ Self ☐ Spouse ☐ Parent

COMPLAINT 1

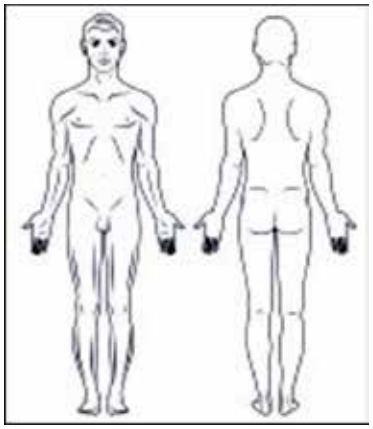
Patient Full Name : _____

Date : _____ Chart : _____

1. I am seeking care today due to :

An accident or injury ☐ Work ☐ Auto ☐ Unknown ☐ A worsening long-term problem ☐ Other ☐

2. Where does it hurt? *(Only circle and explain **ONE AREA OF COMPLAINT PER - SHEET** If more than two sheets needed, additional sheets available at front desk.)*



3. How extreme is your current condition?

0 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 10

Absent Uncomfortable Agonizing

4. When did it start? Date: _____ How often do you feel it?

☐ Constant ☐ Occasional ☐ Intermittent ☐ Frequent

5. What does it feel like?

☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull ☐ Aching ☐ Cramps ☐ Nagging ☐ Sharp

☐ Burning ☐ Shooting ☐ Throbbing ☐ Stabbing ☐ Other _____

6. What other areas of your body does it affect, radiate to, shoot or travel?

_____

7. What tends to worsen the problem? _____

8. What tends to lessen the problem? _____

9. What have you done to relieve the symptoms?

☐ Prescription Medication ☐ Surgery ☐ Over-the-counter Drugs ☐ Acupuncture ☐ Homeopathic Remedies

☐ Chiropractic ☐ Physical Therapy ☐ Massage ☐ Ice ☐ Heat ☐ Other _____

10. How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐
Work / Career	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or Bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard work	☐	☐	☐	☐
Recreational Activities	☐	☐	☐	☐

11. What else should the doctor know about your current condition? _____

COMPLAINT 2

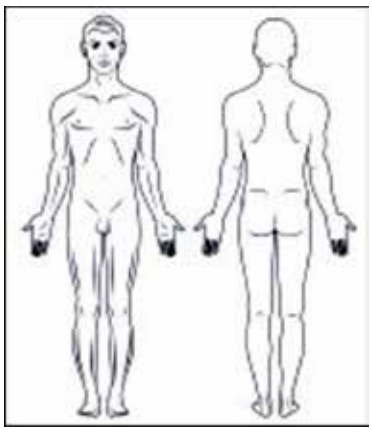
Patient Full Name : _____

Date : _____ Chart : _____

1. I am seeking care today due to :

An accident or injury ☐ Work ☐ Auto ☐ Unknown ☐ A worsening long-term problem ☐ Other ☐

2. Where does it hurt? *(Only circle and explain **ONE AREA OF COMPLAINT PER - SHEET** If more than two sheets needed, additional sheets available at front desk.)*



3. How extreme is your current condition?

0 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 10

Absent Uncomfortable Agonizing

4. When did it start? Date: _____ How often do you feel it?

☐ Constant ☐ Occasional ☐ Intermittent ☐ Frequent

5. What does it feel like?

☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull ☐ Aching ☐ Cramps ☐ Nagging ☐ Sharp

☐ Burning ☐ Shooting ☐ Throbbing ☐ Stabbing ☐ Other _____

6. What other areas of your body does it affect, radiate to, shoot or travel?

_____

7. What tends to worsen the problem? _____

8. What tends to lessen the problem? _____

9. What have you done to relieve the symptoms?

☐ Prescription Medication ☐ Surgery ☐ Over-the-counter Drugs ☐ Acupuncture ☐ Homeopathic Remedies

☐ Chiropractic ☐ Physical Therapy ☐ Massage ☐ Ice ☐ Heat ☐ Other _____

10. How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐
Work / Career	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or Bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard work	☐	☐	☐	☐
Recreational Activities	☐	☐	☐	☐

11. What else should the doctor know about your current condition? _____

Patient Full Name : _____

Date : _____ Chart : _____

12. Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you have HAD or currently HAVE.

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck Pain	☐	☐	Back Problem	☐	☐	Hip Disorders
☐	☐	Knee Injuries	☐	☐	Foot/Ankle Pain	☐	☐	Shoulder Problems	☐	☐	Elbow/Wrist Pain	☐	☐	TMJ Issues	☐	☐	Poor Posture
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Headache	☐	☐	Dizziness	☐	☐	Pins and needles	☐	☐	Numbness
☐	☐	High Blood Pressure	☐	☐	Low Blood Pressure	☐	☐	High Cholesterol	☐	☐	Poor Circulation	☐	☐	Angina	☐	☐	Excessive Bruising
☐	☐	Asthma	☐	☐	Apnea	☐	☐	Emphysema	☐	☐	Hay Fever	☐	☐	Shortness of breath	☐	☐	Pneumonia
☐	☐	Anorexia/bulimia	☐	☐	Ulcer	☐	☐	Food Sensivities	☐	☐	Heartburn	☐	☐	Constipation	☐	☐	Diarrhea
☐	☐	Blurred Vision	☐	☐	Ringing in Ears	☐	☐	Hearing Loss	☐	☐	Chronic ear Infection	☐	☐	Loss of Smell	☐	☐	Loss of Taste
☐	☐	Skin Cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne	☐	☐	Hair Loss	☐	☐	Rash
☐	☐	Thyroid Issue	☐	☐	Immune Disorders	☐	☐	Hypoglycemia	☐	☐	Frequent Infection	☐	☐	Swollen Glands	☐	☐	Low Energy
☐	☐	Kidney Stones	☐	☐	Infertility	☐	☐	Bed-wetting	☐	☐	Prostate Issues	☐	☐	Erectile Dysfunction	☐	☐	PMS Symptom
☐	☐	Fainting	☐	☐	Low Libido	☐	☐	Poor Appetite	☐	☐	Fatigue	☐	☐	Sudden Weight Gain/Loss	☐	☐	Weakness
☐	☐	AIDS	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐	Hepatitis	☐	☐	Multiple Sclerosis	☐	☐	Alcoholism
☐	☐	Chicken Pox	☐	☐	Goiter	☐	☐	HIV Positive	☐	☐	Mumps	☐	☐	Allergies	☐	☐	Diabetes
☐	☐	Gout	☐	☐	Malaria	☐	☐	Polio	☐	☐	Arteriosclerosis	☐	☐	Epilepsy	☐	☐	Heart Disease
☐	☐	Measles	☐	☐	Rheumatic Fever	☐	☐	Scarlet Fever	☐	☐	Sexually Transmitted Disease				☐	☐	Stroke
☐	☐	Typhoid fever	☐	☐	Ulcer	☐	☐	Tuberculosis	☐	☐	Other: _____						

13. Family History Some health issues are hereditary.

Relative	Age (If Living)	State of Health	Illnesses	Age at Death	Cause of Death
		Good / Poor			Natural / Illness
Mother		☐ ☐			☐ ☐
Father		☐ ☐			☐ ☐
Sister 1		☐ ☐			☐ ☐
Sister 2		☐ ☐			☐ ☐
Brother 1		☐ ☐			☐ ☐
Brother 2		☐ ☐			☐ ☐

Patient Full Name : _____

Date : _____ Chart : _____

14. Surgical interventions, which may or may not have included hospitalization.

☐ Appendix Removal ☐ Bypass Surgery ☐ Cancer ☐ Cosmetic Surgery ☐ Elective Surgery
☐ Eye Surgery ☐ Hysterectomy ☐ Pacemaker ☐ Spine ☐ Cesarean
☐ Tonsillectomy ☐ Vasectomy ☐ Other: _____

15. Check the treatments you have received in the PAST or are receiving CURRENTLY.

Past	Currently		Past	Currently		Past	Currently		Past	Currently		Past	Currently	
☐	☐	Acupuncture	☐	☐	Blood Transfusion	☐	☐	Dialysis	☐	☐	Hormone Replacement	☐	☐	Physical Therapy
☐	☐	Antibiotics	☐	☐	Chemotherapy	☐	☐	Herbs	☐	☐	Inhaler	☐	☐	Massage Therapy
☐	☐	Birth Control Pills	☐	☐	Chiropractic Care	☐	☐	Homeopathy	☐	☐	Nutritional Supplements:			

16. Injuries :

☐ Fracture or Broken Bone → Date : _____ How : _____
Location of fracture/broken bone : _____

☐ Spine or Nerve Disorder → Date : _____ How : _____

☐ Knocked Unconscious → Date : _____ How : _____

☐ Injured in an Accident → Type : ☐ Auto ☐ Sports ☐ Fall Other : _____
Date : _____ How : _____
Type : ☐ Auto ☐ Sports ☐ Fall Other : _____
Date : _____ How : _____

☐ Other: → Date : _____ How : _____

17. Social :

Alcohol Use	☐ Never	☐ Daily	☐ Weekly	☐ Amount :	_____
Coffee Use	☐ Never	☐ Daily	☐ Weekly	☐ Amount :	_____
Tobacco	☐ Never	☐ Daily	☐ Weekly	☐ Amount :	_____
Exercising	☐ Never	☐ Daily	☐ Weekly	☐ Amount :	_____
Pain Relievers	☐ Never	☐ Daily	☐ Weekly	☐ Amount :	_____
Soft Drinks	☐ Never	☐ Daily	☐ Weekly	☐ Amount :	_____
Water Intake	☐ Never	☐ Daily	☐ Weekly	☐ Amount :	_____

Hobbies: _____

18. Medications :

Name	Strength	Dosage
1.		
2.		
3.		
4.		
5.		
6.		

Patient Full Name : _____

Date : _____ Chart : _____

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials_____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a seperate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials_____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third party.**

Female_____ **I realize that an X-Ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____**

Initials_____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials_____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials_____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Initials_____ **I understand that my doctor is submitting my xrays, whenever taken, for primary radiological interpretation and report by a specialist.**

If the patient is a minor child, print child's full name: _____

_____ _____

Signature **Date (MM/DD//YYYY)**

The Wellness Center

Patient Full Name : _____

Date : _____ Chart : _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by **The Wellness Center, PC** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **The Wellness Center, PC**. I understand that **The Wellness Center, PC** my refuse to find my subluxations and correct them, if I do not consent to the use or disclosure of my protected health information for the above stated purposes. (My signature on this document is evidence of this consent.)

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **The Wellness Center, PC** is not required to agree to the restrictions that I may request. However, if **The Wellness Center, PC** agrees to restriction that I request, the restriction is binding on **The Wellness Center, PC**.

I understand I have a right to review **The Wellness Center, PC** Notice of Privacy Practices prior to signing this document. **The Wellness Center, PC's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **The Wellness Center, PC**. The Notice of Privacy Practices has been provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and **The Wellness Center, PC's** duties with respect to my protected health information.

The Wellness Center, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing **The Wellness Center, PC's** website www.newbuffalowellness.com by the calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. I have the right to revoke this consent, in writing, at any time, except to the extent that **The Wellness Center, PC** has taken action in reliance on this consent.

X _____

(Patient) (Parent/Guardian) (Date) (Guarantor Signature)

Terms of Acceptance :

When a patient seeks chiropractic healthcare and we accept them for such care, it is essential for both the chiropractor and the patient to have the same objective. Chiropractic's goal is to optimize your body's healing ability without the use of drugs or surgery. As with any profession we have some unique words/language that help define our purpose and procedures. Below are just a few that will help you to understand chiropractic and its objectives.

Health : A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Wellness : The act of being engaged in habits that improve the body's ability to adapt to its environment, thus allowing for a continued innate response to healing and enhanced performance.

Vertebral Subluxation/Joint Subluxation : A misalignment of one or more of the spinal bones, or other joints of the body. This causes an alternation of nerve function and interference to the transmission of those nerve system impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment : An adjustment is the specific application of forces to facilitate the body's correction of obstructions to healing. The primary focus is to correct nerve interference in the spine and to address other biomechanical disruptions in the body that inhibit a complete expression of the body's ability to move, function and heal.

We do not offer to diagnose or treat any medical diseases or medical conditions. The purpose of our procedures is to detect and correct subluxation. However if during the course of a chiropractic examination, we encounter any non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend you seek the services of a healthcare provider who specializes in that area. Our only practice objectives is to eliminate an interference to the expression of the body's innate wisdom.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

X _____ Date _____