Application for Care

The following information is needed in order to better serve you. Please print, and complete.

Name _____ **Date** _____

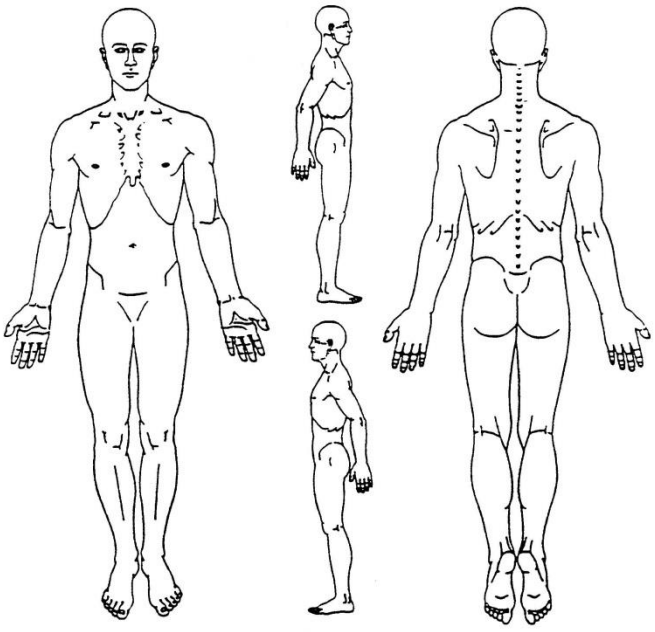
Home Phone _____Cell Phone _____ Work Phone _____
Email Address_____
Address_____
Age _____ Birthdate _____ Marital Status: S M W D # of Children _____

Your Employer _____ Occupation _____ Years on Job____
Employer's Address_____
Your Social Security # _____

Name of Spouse or Parent _____ Their Birth date _____
Spouse Employed By _____ Occupation _____Years On Job ____
Employer Address _____

COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.



MAJOR COMPLAINTS

Please list any condition you are being treated for or are currently experiencing.

_____
_____
_____
_____
_____

Referred to our office by:

_____

Application for Care

Do you have Medicare? Yes____ No____
Is this a Workman's Compensation case? Yes____ No_____
Is your condition due to an accident? Yes ____No _____ Date of accident? _____
Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____
Have you ever been in an auto accident? Past Year __ Past 5 Yrs __ Over 5 Yrs __ Never ____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

Name _____ Address: _____
Phone: _____

Correspondence Authorization

I authorize WELLNESS MONTANA to correspond with my medical provider,
_____, of my condition and progress if needed.

Patient Signature _____
Date _____

Consent for Use and Disclosure of Health Information

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Wellness Montana (406)-522-5433 , Address: 8332 Huffine Lane Ste 5, Bozeman, MT 59718

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE: I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations and have received a copy of this Consent and Notice of Privacy Practices.

Signature: _____Date: _____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

WELLNESS MONTANA

Confidential Patient Case History

What is your major complaint?

_____

_____

List surgical operation and years: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers
☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills
Others: _____

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable ☐ Do you use a bed board? _____
Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports
Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never
Describe: _____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____
Have others in your family had such disorders? ☐ Yes ☐ No When? _____

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything other than surgery?	☐	☐	_____

DO YOU:			
Now take vitamins or minerals?	☐	☐	_____
Think you may need vitamins or minerals?	☐	☐	_____
Have an allergy to any drug?	☐	☐	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Have you ever been told you have high cholesterol or triglycerides? YES/NO

Have you ever been diagnosed with high blood pressure? YES/NO

Have you ever been diagnosed with diabetes? YES/NO

Have you ever been diagnosed as PRE- diabetic or metabolic syndrome? YES/NO

How many days a week do you skip a meal? (3/meals/day) _____

How many days a week do you consume “fast food”, “refined food”, or “pre-prepared food”?

(0) (1-3) (4-6) (7+)

How many servings of fruit do you eat per day?

(0) (1-3) (4-6) (7+)

How many servings of vegetables do you eat per day?

(0) (1-3) (4-6) (7+)

Do you regularly drink 1 or more per day of the following: (circle all that apply)

Soda Diet Soda Coffee Juice Milk Alcohol

How many servings of refined sugar do you consume per day? (circle all that apply)

(0) (1-3) (4-6) (7+)

Please list all nutritional supplements/vitamins/ you take regularly.

Supplement Name	Frequency	Brand or where it was purchased
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____