Application for Care

Name _____ Birth Date ____ / ____ / ____ Sex ___ M ___ F
Weight _____
Height _____
Parent(s)/Guardian(s) Name(s) _____
Address _____ City _____ State ____
Zip _____
Phone (H) _____ (C) _____
(W) _____
Email _____
Referred By _____

Purpose for Contacting Us

_____
Other Doctors seen for this condition? Yes ___ No ___ If Yes, Name and Prior Treatments
_____
_____
_____
Other Health Conditions
_____

Please check any of the following conditions your child has suffered in the last 6 months:

◯ Ear Infections	◯ Scoliosis	◯ Car Accident	◯ Temper Tantrums	◯ Growing/Back Pain
◯ Asthma	◯ Bed Wetting	◯ Difficulty Nursing	◯ Head Banging	◯ Headaches
◯ Colic	◯ Seizures	◯ Chronic Colds	◯ Sleeping Disorders	◯ Vision Problems
◯ Digestive Problems	◯ ADHD/ADD/Autism	◯ Recurring Fevers	◯ Constipation	◯ Tortecollis
◯ Flathead Syndrome	◯ Allergies	◯ Rashes	◯ Vaccine Reaction	◯ Diarrhea

Family History
_____

Previous Chiropractor _____Date of Last Visit ___/___/___ Reason
_____
Pediatrician _____ Date of Last Visit ___/___/___ Reason
_____

Are you satisfied with the care that your child received there? Yes ___ No ___

Number of Antibiotic Doses Your Child Has Taken In the Last 6 Months _____ In Their Lifetime
_____
Number of Other Prescription Medications Your Child Has Taken In the Last 6 months _____ In Their Lifetime _____

Vaccination History

◯ Flu/H1N1 (Prenatal)	◯ Rotavirus (2 mo)	◯ Rotavirus (4 mo)	◯ Pneu (12 mo)	◯ Hib (18 mo)
◯ HepB (Birth)	◯ HepB (2 mo)	◯ DTap (6 mo)	◯ MMR (12 mo)	◯ HepA (18 mo)
◯ DTap (2 mo)	◯ DTap (4 mo)	◯ Polio (6 mo)	◯ Varicella (15 mo)	◯ Flu/H1N1 (18 mo)
◯ Polio (2 mo)	◯ Polio (4 mo)	◯ Hib (6 mo)	◯ HepA (15 mo)	◯ Flu/H1N1 (2.5 yrs)
◯ Hib (2 mo)	◯ Hib (4 mo)	◯ Flu/H1N1 (6 mo)	◯ DTap (18 mo)	◯ DTap (4-6 yrs)
◯ Pneu (2 mo)	◯ Pneu (4 mo)	◯ Flu/H1N1 (7 mo)	◯ Polio (18 mo)	◯ Polio (4-6 yrs)
◯ MMR (4-6 yrs)	◯ Varicella (4-6 yrs)	◯ Flu/H1N1 (4-6 yrs)	◯ Tetanus	◯ Other

Prenatal History

Obstetrician/Midwife _____ Complications During Pregnancy _____

Induced Labor? Yes ___ No___ If Yes, How? _____ Doctor Assisted Labor? Yes ___ No___ If Yes, How? _____

Ultrasounds During Pregnancy? Yes ___ No ___ If Yes, How Many? ___ Medications during Pregnancy _____

Cigarette/Alcohol Use During Pregnancy? Yes ___ No ___ Birthing Location: Home ___ Birth Center ___ Hospital ____

Birth Interventions: Forceps ____ Vacuum Extraction ____ Planned Caesarian Section ____ Emergency Caesarian ____

Delivery Complications? Yes ___ No ___ If Yes, Please List _____

Genetic Disorders? Yes ___ No____ If Yes, Please List _____

Birth Weight _____ Birth Length _____ APGAR Scores Immediately Following Birth _____ 5 Minutes _____

Feeding History

Breastfed? Yes ___ No ___ If Yes, How Long? _____ Formula? Yes ___ No ____ How Long? _____ What Type? ____

Solids introduced at _____ Months Cow's milk introduced at _____Months

Food/Juice allergies or intolerances? Yes ___ No____ If Yes, Please List _____

Developmental History

During infancy and childhood, your child's spine is vulnerable to stress and should be routinely checked by a chiropractor for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age could your child:

Application for Care

Respond to Sound _____ Respond to Visual Stimuli _____ Hold Head Up _____ Sit Up Unassisted _____
Cross Crawl _____ Stand Alone _____ Walk Unassisted _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, down stairs, etc.) Was this the case with your child? Yes ____ No ____

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) Yes ___ No____ If Yes, Please List
_____
Has your child ever been involved in a car accident? Yes ___ No ___ If Yes, When?
_____
Has your child been seen on an emergency basis? Yes ___ No ____ If Yes, Why and When?
_____
Other Injuries/Traumas Not Listed Above
_____
Prior Surgeries? Yes ___ No ____ If Yes, Please List
_____
Menarche ? Yes ___ No ____ Age _____
Does your child have difficulty interacting with schoolmates or friends? Yes ___ No ____
Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? Yes __ No__
What changes (if any) in your child's health or behavior would you like accomplished?
_____
_____
_____

Childhood Diseases

○ Chicken Pox	Age _____	○ Mumps	Age _____	○ Rubella	Age _____
○ Whooping Cough	Age ____	○ Rubeola	Age _____	○ Other _____	Age _____

We are here to serve you and answer questions. Your participation is vital and helps to determine your results.

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

Name _____ Address: _____
Phone: _____

Consent for Treatment

Chiropractic is a natural approach to health care utilizing the body's innate abilities. We do not diagnose or treat any disease or medical condition. Our primary focus is detecting and treating vertebral subluxation complex.

I acknowledge that I have read and understand this information. I authorize Dr. Anderson to examine me (or my child _____) and provide the Chiropractic care deemed appropriate.

Patient Signature _____
Date _____

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: Contact Officer: **Rachel Towles 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.

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ **Date** _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL F – FREQUENT
C – CONSTANT

O F C

GENERAL

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness/depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLE & JOINT

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ Pain between shoulders
Pain or numbness in:
☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful tail bone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen joints

O F C

GASTRO-INTESTINAL

☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Distension of abdomen
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Gall bladder trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

EYES, EARS, NOSE &THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental Decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noises
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Tonsillitis

O F C

CARDIO-VASCULAR

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ Swelling of ankles

RESPIRATORY

☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficult breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Wheezing

SKIN

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Inability to control kidneys
☐ ☐ ☐ Kidney infection or stones
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY

☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excessive menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge
☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Cancer
☐ Chorea
☐ Cold sores
☐ Diabetes
☐ Diphtheria
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Fever blisters
☐ Goiter
☐ Gout
☐ Heart disease
☐ Influenza
☐ Lumbago
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Stroke
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal disease
☐ Whooping cough

What is your major complaint?

_____

_____

List surgical operation and years: _____

WELLNESS MONTANA

Confidential Patient Case History

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	☐	☐	☐	☐

Pediatric Application and History

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____