THE Chiropractic WELLNESS CENTER

109A South Center Ave
Merrill, WI 54452
(715) 539-9797

WELCOME TO WELLNESS – WE'RE GLAD YOU ARE HERE

Name: _____ Age: _____ Today's Date: _____
Address: _____City: _____ St: ____ Zip: _____
Phone (home): _____ (cell)_____ Preferred Contact: Home / Cell / Either
SSN#:_____ Birth date: _____/_____/_____ No. of Children: _____
E-Mail: _____ I Am: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Widow
Occupation/Employer/School: _____
Emergency Contact/Relationship: _____Phone: _____
How did you hear about us? ☐ Location ☐ Doctor ☐ Internet ☐ Ins Co Referral ☐ Friend or Family Member
Who can we thank for referring you? _____

We promise to treat you with respect, compassion, and understanding.

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Reason for today's visit? _____

If you have no symptoms or complaints, and are here for wellness services, please check (√) here ☐ and skip to **"Your Health History"** Or, describe your **chief area of complaint**, including the effect it has on your life:

_____

_____

On a scale of 0 – 10, please rate your pain (with 10 being unbearable and 0 being no pain):

Please X the line: 0 ●——————————● 10

If you are experiencing pain, is it: ☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the condition or concern started, it is: ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse: _____

Does it interfere with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this condition (please list):

☐ Chiropractor _____

☐ Medical Doctor _____

☐ Other / Alternative Care _____

List any medications/supplements you are currently taking: _____

_____

Describe your current stress level (0 = none / 10 = extreme): Work: _____ Home: _____

Rate each Area on a scale of Poor – Good – Excellent

Diet:	☐ Poor	☐ Good	☐ Excellent	Sleep:	☐ Poor	☐ Good	☐ Excellent
Exercise:	☐ Poor	☐ Good	☐ Excellent	General Health:	☐ Poor	☐ Good	☐ Excellent

UNDERSTANDING YOUR HEALTH HISTORY

Please check (√) all symptoms you have ever had, even if they do not seem related to your current condition.

- □ Headaches
- □ Pins and Needles in arms
- □ Dizziness
- □ Numbness in fingers
- □ Fatigue
- □ Sleeping problems
- □ Diarrhea
- □ Cold Sweats
- □ Mood Swings
- □ Kidney/Bladder
- □ Neurological
- □ Osteoporosis
- □ Liver Disease
- □ Bleeding Disorder
- □ Diabetes
- □ Thyroid
- □ Alcohol or drug abuse
- □ Mental Health
- □ Hepatitis
- □ HIV
- □ Psoriasis/Eczema
- □ Anemia
- □ Arthritis
- □ Accident - Major
- □ High Cholesterol
- □ Lung Disease
- □ Stomach Ulcer

Family Health Profile:
At the Wellness Center we are not only interested in your health, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____
Spouse _____
Mother _____
Father _____
Brothers _____
Sisters _____
Others _____

Have you ever:

Bought bottled water:	□ Yes, currently	□ Yes, in the past	□ No, never
Belonged to a health club / gym?	□ Yes, currently	□ Yes, in the past	□ No, never
Consumed Vitamins or supplements:	□ Yes, currently	□ Yes, in the past	□ No, never

YOUR HEALTH PROFILE

Why this section is important: As a Wellness Center, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Please answer the following questions the best you can:

YOUR CHILDHOOD YEARS:

Did you have any childhood injures?	Yes	No	Unsure	Did you suffer any other traumas (physical or emotional)	Yes	No	Unsure
Did you have any serious falls as a child?	Yes	No	Unsure	Were you vaccinated?	Yes	No	Unsure
Did you play youth sports?	Yes	No	Unsure	As a child, were you under regular Chiropractic care?	Yes	No	Unsure
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed , trees)	Yes	No	Unsure	Did you have any surgery?	Yes	No	Unsure
Was there any prolonged use of medicine such as antibiotics or an inhaler?	Yes	No	Unsure	Were involved in any other accidents as a child?	Yes	No	Unsure
Did you take /use any drugs?	Yes	No	Unsure	Did you have a difficult or traumatic birth?	Yes	No	Unsure

You're almost done, just one more page!

YOUR HEALTH PROFILE - CONTINUED

Please tell us about your health as an adult (18 to Present):

YOUR ADULT YEARS:

	YES	IN THE PAST	NO		YES	IN THE PAST	NO
Do/did you use tobacco?	☐	☐	☐	Do/did you play adult sports?	☐	☐	☐
Do/did you drink alcohol?	☐	☐	☐	Do/did you participate in extreme sports?	☐	☐	☐
Have you been in any accidents?	☐	☐	☐	Have you had any surgeries?	☐	☐	☐
Do you consume soda on a daily basis?	☐	☐	☐	Do you take daily medications? (legal or not)	☐	☐	☐

PAYMENT INFORMATION

How will payment be made? ☐ Self / Cash ☐ Health Insurance ☐ Auto/Injury Insurance ☐ Work Accident
☐ Medicare ☐ Medicaid/BadgerCare ☐ Other: _____

Carrier Name: _____

Primary Insured: (if not you): _____ DOB: _____

Insurance SSN or Group # _____

Date of Injury (If applicable): _____ Claim # _____

Auto Ins Name: _____ Attorney Name: _____

INSURANCE ASSIGNMENT & RELEASE OF RECORDS

I certify that I, and /or my dependent(s), have insurance coverage with the above Carrier and assign directly to The Chiropractic Wellness Center all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Chiropractic Wellness Center may use my health care information and may disclose such information to my insurance Carrier(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I hereby authorize the doctors at The Chiropractic Wellness Center to perform an examination, including x-rays if indicated, and to provide chiropractic services to me (or my dependents) based on the information provided herein.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please **Print Name** of Patient, Parent, Guardian or Personal Representative

☐ YES ☐ NO Please Text or E-mail me appointment reminders when needed
☐ YES ☐ NO I would like to discuss payment options in order to afford care that I may need.
☐ YES ☐ NO I am interested in long-term wellness for my family.

Welcome to our office! Want more information? Visit us online at KidsChiroWI.com or on Facebook

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