Confidential Patient Information for Natural Way Wellness Center

Today's Date _____

Name _____ Sex _____ Marital Status _____ Date of Birth ____/_____/____ Age _____
First Name, Middle Initial and Last Name | M or F | S or M | Mo/Day/Yr

Address _____ Apt #_____ City _____ State _____ Zip_____
Include Street type such as St., Ave., etc.

Home Phone_____ Work Phone_____ Cell Phone_____
Area Code/Number | Area Code/Number | Area Code/Number

As a courtesy to our patients we offer text message appointment reminders. Who is your cell phone provider? _____
Sprint/AT&T/Verizon/T-Mobile, etc

Patient Social Security # _____-_____-_____ Driver's License No._____ Issuing State_____

_____
Patient's Occupation | Company Name | Location

Email Address_____

Is your visit due to an accident? __ No __ Yes What type? ☐ Auto ☐ Work ☐ Other (if auto, please see receptionist for an injury report)

Would you like a free acupuncture consultation with Dr. Yang for any of the following reasons?

☐ **Allergies** ☐ **Arthritis** ☐ **Smoking Cessation** ☐ **Decrease Blood Pressure** ☐ **Pain**

Name of Primary Care Physician:_____ Address:_____

Who referred you to our office?_____ To which doctor were you referred?

☐ Dr. Brian Schnitta ☐ Dr. Cindy Stoneking ☐ Dr. Brian Rissman ☐ Dr. Andy Krueger ☐ Dr. Jeff Breithaupt

Reason for consulting our office?_____

☐ Spouse Information ☐ Significant Other Information ☐ Guardian Information (Please check which applies)

Full Name_____ Date of Birth_____/_____/_____ Social Security #_____-_____-_____
First Name, Middle Initial, Last Name | Mo/Day/Yr

_____
Occupation | Company Name | Work Phone Number

Do you have insurance? ☐ Yes ☐ No Company _____

I.D. No. _____ Policy Group No. _____

Are you the primary insured? ☐ Yes ☐ No If not, please tell us who is: ☐ Spouse ☐ Significant Other ☐ Parent ☐ Guardian

Name of insured if not yourself_____ Employer of Insured_____

Do you have a secondary insurance policy? ☐ Yes ☐ No Company _____

I.D. No. _____ Policy Group No. _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charges directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Natural Way Wellness Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Natural Way Wellness Center and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above is true and correct.

Patient's Signature _____ **Date**_____

Parent or Guardian Signature (if patient is a minor)_____ **Date**_____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT…

As a full spectrum Wellness office, 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.

THE BEGINNING YEARS (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Did you have any childhood illnesses?	Y / N	Did you take/use any drugs?	Y / N
Did you have any serious falls as a child?	Y / N	Did you have any surgery?	Y / N
Did you play youth sports?	Y / N	Were you vaccinated?	Y / N

Have you fallen/jumped from a height over three feet? (i.e.: crib, bunk bed, trees) Y / N

Were you involved in any accidents (i.e.: car, bike, skateboard, sports, etc) as a child? Y / N

Was there any prolonged use of medicine such as antibiotics or an inhaler? Y / N

Did you suffer any other traumas? (physical or emotional) Y / N

As a child, were you under regular chiropractic care? Y / N

ADULT (18 TO PRESENT)

Do/did you smoke?	Y / N	Do/did you play any adult sports?	Y / N
Do/did you drink alcohol?	Y / N	Do/did you participate in extreme sports?	Y / N
Have you been in any accidents?	Y / N	Are you pregnant?	Y / N
Have you had any surgery?	Y / N		

On a scale of 1-10, describe your stress level: (0=none / 10=extreme)

Occupational Stress _____

Personal Stress _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Sleep _____

Exercise _____ General Health _____

Addressing the Issues That Brought You to the Office

If you have no symptoms, and are here for wellness services, please check here_____ **"Wish to Have Chiropractic Wellness Services"** and skip to **"Family Health Profile"**. Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it… (circle all that apply)

sharp dull comes and goes constant travels

Since the problem started, it is…(circle all that apply) about the same getting better getting worse

What makes it worse:_____

Yes, the pain interferes with…(circle all that apply)

work sleep walking sitting hobbies leisure driving other

Other Doctors seen for this problem (please list): Chiropractor _____

Medical Doctor _____

Other _____

Personal Medical History (if any of the following are relevant to your medical history, please check the accompanying box:)

☐ Cancer	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ Digestive Disorders
☐ Polio	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Sinus Trouble
☐ Tuberculosis	☐ Convulsions	☐ Nervousness	☐ Backaches
☐ High Blood Pressure	☐ Epilepsy	☐ Asthma	☐ Numbness
☐ Heart Trouble	☐ Concussion	☐ Dizziness	☐ Arthritis
☐ Diabetes	☐ Hepatitis	☐ German Measles	☐ Venereal Disease

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

☐ Headaches	☐ Loss of smell	☐ Fainting	☐ Neck pain
☐ Pins/Needles in arms	☐ Pins/Needles in legs	☐ Back pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiffness	☐ Cold hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold sweats	☐ Light sensitivity	☐ Problem urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual pain	☐ Menstrual irregularity	☐ Ulcers

Please list any medications you are taking:_____

How does this condition currently interfere with your life and ability to function? Place "✔" or "X" in box.

	no affect	mild affect	moderate affect	severe affect			no affect	mild affect	moderate affect	severe affect
sitting						household chores				
rising out of a chair						lifting objects				
standing						reaching overhead				
walking						showering / bathing				
lying down						dressing myself				
bending over						getting to sleep				
climbing stairs						staying asleep				
using a computer						concentrating				
getting in / out of car						exercising				
driving a car						yard work				
looking over shoulder						work / career				
caring for family						recreational activities				
grocery shopping						personal relationships				
Short Term Health Goals						**Long Term Health Goals**				

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature_____ Date_____

Parent or Guardian Signature (if patient is a minor)_____ Date_____