ALL ABOUT WELLNESSS

TODAYS DATE_____/_____/_____ **IS TREATMENT DUE TO A CAR ACCIDENT OR WORKER'S COMPENSATION? Y / N ?**

PATIENT INFORMATION

Last Name	First	Middle		Marital Status
EMAIL ADDRESS:			☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	☐ Single ☐ Separated ☐ Partnered ☐ Divorced ☐ Married ☐ Widowed

Is this your legal name? ☐ Yes ☐ No	Former Name (optional)	Sex ☐ M ☐ F	Birth Date / /	Age

Street Address	City	State	ZIP Code	Social Security - -	Home Phone # ( ) -

PO Box	City	State	ZIP Code	Cell Phone # ( ) -

Occupation	Employer	Employer Phone # ( ) -

How did you hear about our office? (Please check one) ☐ Dr. _____ ☐ Insurance Plan ☐ Family ☐ Friend
☐ Website ☐ Yellow Pages ☐ Flyer/ Mailing ☐ Other_____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND ID TO THE RECEPTIONIST)

Person Responsible for Bill:	Birth Date / /	Address (if different)	Home Phone # ( ) -
Is this person a patient here? ☐ Yes ☐ No			Cell # ( ) -

Are you covered by insurance for this visit? ☐ Yes ☐ No **Please indicate primary insurance:** _____
DO YOU HAVE A FLEX SPENDING OR HSA ACCOUNT? Y/N_____

Subscribers Name:	Subscriber's SS # - -	Birth Date / /	ID/ Policy #	Group #	Co-Payment

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary Insurance (if applicable) Subscriber's Name:	ID/ Policy #	Group #

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

IN CASE OF EMERGENCY

Name of Local Relative or Friend	Relationship to Patient	Home Phone # ( ) -	Work Phone # ( ) -

◆**Health Insurance:** Although we accept insurance in this office, not all insurance companies choose to cover chiropractic. If you find that it does cover the services offered in our office, we will be happy to send claims directly to your insurance company. If we find out that you're responsible for your health care expenses don't be alarmed. **Most of our patients are on one of the Chiropractic Health Care Plans** discussed above. Regardless of your situation, this is the best way to keep costs down and get you all the care you need.

The above information is true to the best of my knowledge. I authorize the doctors of All About Wellness (AAW) to provide myself or my child with reasonable and proper care according to today's standards/ I authorize my insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim. I also authorize AAW or the insurance company to release any information required to process my claim. I understand that AAW has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to AAW, I agree to forward to the office all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I understand that I am financially responsible for the account even though insurance may be pending on all or a portion of the charges.

Signature of Patient/ Guardian: _____ Date: _____

For Office Use Only
Date: ____________
Acct #: ____________
Patient Height ____________
Patient Weight ____________
Patient BMI ____________
Patient Blood Pressure ________

Patient Intake Form

Name: ______________________________

Race (circle only 1) American Indian Alaska Native
Asian White
Black or African American
Native Hawaiian Other Pacific Islander
Declined to State

Ethnicity (circle only 1) Declined to State Hispanic or Latino
Not Hispanic or Latino

Preferred Language ______________________________ Email Address ______________________________

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: ____________________

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: ____________________

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: ____________

Briefly describe the accident, injury or illness: ______________________________

____

____

____

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

______________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

______________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

______________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

______________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

______________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

List any tests, studies or medications received for this condition:

❑Tests/Studies: ______________________________

❑Medications: ______________________________

Where you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ____________ Transported by? ❑Ambulance ❑Police ❑Other: ____________

Date Admitted: ____________ Date Released: ____________ Length of Stay: ____________

List the hospital procedures received: ______________________________

List symptoms you are experiencing today: Choose the severity level associated with each symptom

______________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

______________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

______________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

______________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

______________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: _____ To: _____

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) _____

What type of work do you do?_____

_____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No _____

_____

List any past conditions you may have had: _____

HABITS

❑Current Every Day Smoker ❑Current Some Day Smoker

❑Former Smoker ❑Never Smoker

❑Drinking Alcohol: (Cups/day): _____ ❑Coffee Cups/Day: _____

❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	❑

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____	Allergy: _____
Reaction: _____	Reaction: _____
Start Date: _____	Start Date: _____
End Date: _____	End Date: _____
Allergy: _____	Allergy: _____
Reaction: _____	Reaction: _____
Start Date: _____	Start Date: _____
End Date: _____	End Date: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

Other _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS

- ❑ Allergy(What) _____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS	CARDIO-VASCULAR	SKIN OR ALLERGIES	FOR FEMALES ONLY
❑ Backache	❑ High Blood Pressure	❑ Bruising Easily	❑ Cramps
❑ Foot Trouble	❑ Low Blood Pressure	❑ Dryness	❑ Hot Flashes
❑ Hernia	❑ Chest Pain	❑ Eczema	❑ Irregular Cycle
❑ Pain Between Shoulders	❑ Heart Trouble	❑ Hives or Allergy	❑ Painful Periods
❑ Painful Tail Bone	❑ Poor Circulation	❑ Itching	❑ Vaginal Discharge
❑ Stiff Neck	❑ Rapid Heart	❑ Sensitive Skin	❑ Pregnant Now?
❑ Spinal Curvature	❑ Slow Heart	❑ Skin Eruptions	_____ Last Pap Date
❑ Swollen Joints	❑ Strokes		_____ Last Menstrual Cycle
❑ Tremors	❑ Swelling Ankles		
	❑ Varicose Veins		

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____