BASIC INFORMATION

Today's date ___/___/_____

Full Name _____

Preferred Name _____

Current Address _____

_____

Home phone: (___) _____

Work phone: (___) _____

Cell phone: (___) _____

Date of Birth___/___/_____

S.S. #: _____

*EMAIL*_____

(Circle One) Male or Female

Marital Status:

Single Married Divorced

Legally Separated Widowed

Employer: _____

Occupation: _____

How Long have you been there?_____

Name of Insurance:

Primary: _____

Secondary: _____

Patient Relation to Insured:_____

Insured DOB:_____/____/_____

Primary Care Physician's name:

_____

Do you have reliable transportation? ____

How did you hear about us? _____

What main reason brings you in to us today? _____

_____

CURRENT PHYSICAL HEALTH

What is(are) your major concern(s) about your health? List them.

_____ _____ _____

_____ _____ _____

How are these health conditions/concerns affecting your life? _____

_____

How long has it been since you have really felt good? _____

GOALS AND EXPECTATIONS

If you could change one thing about your physical health what would it be?

_____

And your emotional health? _____

And your nutritional (chemical) health? _____

What are your expectations from us as a wellness center? _____

What are your wellness goals/expectations that you would like to accomplish?

_____

HEALTH HISTORY

List all major injuries and/or surgeries you have ever had with approximate dates.

_____

_____

Check any of the following conditions that apply to you:

- o Acne
- o Alcohol/drug abuse
- o Anemia
- o Arthritis
- o Artificial bones/joints
- o Artificial valves
- o Asthma
- o Cancer
- o Chemotherapy
- o Chronic bad breath
- o Congenital heart defect
- o Depression
- o Diabetes
- o Difficulty breathing
- o Emphysema
- o Fainting/seizures
- o Frequent neck/back pain
- o Gingivitis
- o Glaucoma
- o Heart attack/stroke
- o Heart murmur
- o Hepatitis
- o High blood pressure
- o HIV+/AIDS
- o Low blood pressure
- o Lyme Disease
- o Pacemaker
- o Psychiatric disorder
- o Severe/frequent headaches
- o Shingles
- o Sinus problems
- o Skin condition
- o Tuberculosis
- o Ulcers/Colitis
- o Venereal dis
- o Other:_____

List any family members that have experienced the same conditions as you.

_____ _____

_____ _____

LIFESTYLE

Check mark those that apply to you.

Exercise
__none
__moderate
__daily
__heavy

Work Activities
__mostly sitting
__mostly standing
__light labor
__heavy labor

Stress Level
__none
__low
__moderate
__high

Values
Please list your interests in order of importance from 1 to 7 (1 being most important.)

____Financial ____Family
____Social ____Physical
____Mental ____Spiritual
____Work

Family

	Name	Age	Name	Age
Spouse	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____

Other family members currently living with you:

_____

Check mark any of the following major life changes that has occurred in the past 12 months.

___Marriage/divorce
___Moved homes
___Job change
___Gave birth/new addition to the family
___Death of a family member or close friend

CHEMICAL (NUTRITIONAL) HEALTH

List all medications (or attach them if you brought a list) including dosages and how long you have been taking them.

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

List all vitamins and/or supplements including dosages and how long you have been taking them.

_____ _____
_____ _____
_____ _____

How many bowel movements do you have per day/week? _____

Checkmark the answer that best describes the following:

Typical color of your urine:

LT yellow ____
Yellow ____
Orange ____
Red ____
Brown ____
Green ____

Typical clarity of your urine:

Clear ____
Slightly Cloudy ____
Very Cloudy ____
Mucous ____
Bloody ____

Date of last dental cleaning _____
Number of fillings _____
Type of fillings (i.e. gold, composite, ceramic, etc.) _____
List any dental surgeries or manipulations you have had including braces, root canals, teeth removed, etc.

_____

EMOTIONAL HEALTH

Have you been diagnosed with any mental disorders? List them with the date of diagnosis.

_____

Do you frequently experience emotional highs and lows? Describe these emotions. _____

_____

For the following, circle "Y" for yes or "N" for no.

I love myself. Y N
I am satisfied with my life. Y N
I enjoy my job. Y N
I tend to have great relationships. Y N
I have a stable, healthy relationship with my spouse/significant other. Y N

PATIENT ACKNOWLEDGEMENT

I, _____, hereby declare that all the information I provided is true and current to the best of my knowledge. I recognize Nepute Wellness Center's ability to provide the best care possible and give them permission to advise and treat me accordingly as well as obtain payment for the treatment in order to carry out its health care operations.
I also acknowledge that Nepute Wellness will keep all of my information private according to the required Protected Health Information (PHI) policy. The Nepute Wellness' Privacy Notice contains all guidelines to protecting my information and I am aware that I can request to read it at any time. It is provided at the front desk for my convenience. I acknowledge that Nepute Wellness reserves the right to change its privacy practices that are described in the Privacy Notice, in accordance with applicable law.

I have read and understand the foregoing notice and all of my questions have been answered to my full satisfaction in a way that I understand it.

_____ _____/_____/_____
Print name of patient Today's date

_____ or _____
Signature of patient Signature of legal representative

_____
Relationship

X-RAY RELEASE FORM

Patient name _____
Phone (_____) _____-_____
Date of Birth _____/_____/_____
Address _____
_____
_____

X-ray Assignment Agreement

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and the charges for these services will be submitted to my insurance carrier, worker's compensation, state bureau and/or my attorney in the case of a personal injury.

In the event I receive payment for the services, I agree to promptly remit payment to Nepute Wellness.

I assign my insurance benefits and rights to payment to Nepute Wellness and authorize them and their agents to bill and release information to my insurance company, attorney, and/or any third party payer. I authorize my treating physician, insurance company, attorney and/or any third party payer to provide Nepute Wellness with any inforamation concerning my claim, their service, and/or payment for the services provided.

By signing below I acknowledge that I have read, understand and agree to the above provisions.

_____ _____
Signature Date