



BASIC INFORMATION

Today's date ___/___/___
Full Name _____
Preferred Name _____
Current Address _____
City, State, Zip: _____
Cell phone: (____) _____
Work phone: (____) _____

Date of Birth ___/___/___
S.S. #: _____

EMAIL _____

(Circle One) Male or Female
Marital Status:
Single Married Divorced
Legally Separated Widowed

What main reason brings you in to us today? _____

Employer: _____
Occupation: _____
How Long have you been there? _____
Name of Insurance: _____
Primary: _____
Secondary: _____
Patient Relation to Insured: _____
Insured DOB: ___/___/___

Primary Care Physician's name and number:

Do you have reliable transportation? ___
How did you hear about us? _____

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

What are your wellness goals that you would like to accomplish? What do you want?

What are your expectations from us as a wellness center?

Do you want to patch your symptoms or fix your health? Circle One PATCH FIX
Patch (90 days to alleviate acute pain) Fix (12-18 months to correct issues)

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:

- | | |
|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Artificial bones/joints | <input type="checkbox"/> Severe/frequent headaches |
| <input type="checkbox"/> Artificial valves | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin condition |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic bad breath | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Venereal dis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> 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.)

- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Financial | <input type="checkbox"/> Family |
| <input type="checkbox"/> Social | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Mental | <input type="checkbox"/> Spiritual |
| | <input type="checkbox"/> 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.

- | | |
|---|--|
| <input type="checkbox"/> Marriage/divorce | <input type="checkbox"/> Pregnant, gave birth/new addition to the family |
| <input type="checkbox"/> Moved homes | <input type="checkbox"/> Death of a family member or close friend |
| <input type="checkbox"/> Job change | <input type="checkbox"/> Any international travel |

CHEMICAL (NUTRITIONAL) HEALTH

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

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If there was a way to get you off these medications, would you be interested? **YES or NO?**

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 protect 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

Signature of patient

or

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 ensure 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 information 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