



Welcome! Please take a few minutes to complete our New Patient Intake Form completely and to the best of your knowledge. Let our staff know if you have any questions.

PATIENT INFORMATION

Date: _____ Patient Name: _____
First Name Middle Initial Last Name

Age: _____ Birthdate: _____ Sex: M F Social Security #: _____

Address: _____
City: _____ State: _____ Zip: _____

E-Mail: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Best Time and Primary Number to reach you: _____

Occupation: _____ Full-Time Part-Time

Employer / School: _____

Employer / School Address: _____ City: _____ Zip: _____

Married Partnered Single Separated Divorced Widowed Minor

Spouse's Name: _____ Spouse's Employer: _____

How did you hear about our office? _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relation: _____ Phone: _____

ACCIDENT INFORMATION

Is your visit today due to an accident? Yes No *If Yes, Please complete the remainder of this section*

Type of Accident: Auto Work Home Other Date of Accident: _____

To whom have you made a report of your accident? Auto Insurance Employer Worker Comp Other

Attorney (if applicable): _____

INSURANCE INFORMATION

Primary Health Insurance Name: _____
Information for Primary Insured

Name: _____ Birth Date: _____ Relationship to Patient: _____

Secondary Health Insurance Name: _____
Information for Primary Insured

Name: _____ Birth Date: _____ Relationship to Patient: _____

DEMOGRAPHICS

Completion of this section is optional

Language: _____ Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: Alaskan Native American Indian Asian Black or African American

Native Hawaiian Other Pacific Islander White Other

FINANCIAL RESPONSIBILITY

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Wellness One and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Wellness One of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Wellness One and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Patient
Initials: _____

ASSIGNMENT OF BENEFITS

By signing this form, I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Wellness One for all covered medical services and supplies provided to me during all courses of treatment and care provided by Wellness One and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Wellness One, and will constitute a continuing authorization, maintained on file with Wellness One, which will authorize and allow direct payment to Wellness One of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Wellness One.

Wellness One may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end one year from the date signed on this form.

Patient
Initials: _____

MEDICAL RECORDS RELEASE

Please list the information of any individual(s) you would like to have access to your medical and financial information (i.e. spouse, child, PCP)

By signing this form, I authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment to be released to the following individual(s):

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____

Signature of Patient, Parent, Guardian, or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

PATIENT HEALTH HISTORY

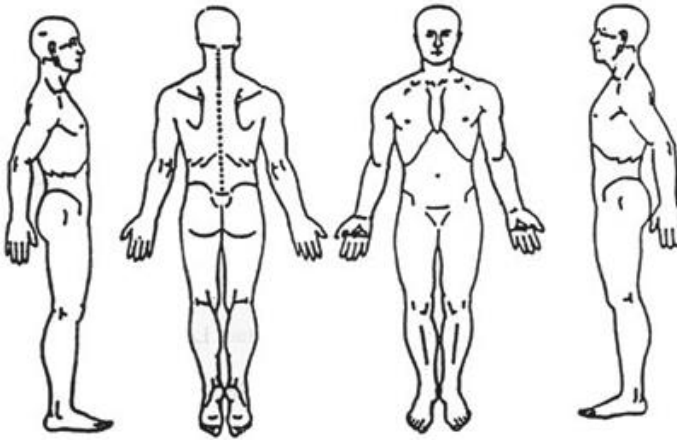
1. Which option best describe your current ideas and values towards health?

- Treatment Only I only consult a doctor when I have a problem/symptoms and discontinue care as soon as the symptoms leave
- Early Detection In addition to symptom relief, I see doctors occasionally to detect problems early before they become serious
- Prevention I'm conscious about my health, diet and exercise. I work to maintain my health and prevent illness
- Wellness I actively inform myself about true health and I am concerned with the long-term effects of things on my health

2. Is this your first time seeing a chiropractor? Yes No

If No, what was your previous experience? _____

3. Indicate with an X on the diagrams below where you are having pain / symptoms



List/describe your symptoms in order of severity

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

How often do you experience your symptoms?

- Constantly (76 - 100% of the time)
- Frequently (51 - 75% of the time)
- Occasionally (26 - 50% of the time)
- Intermittently (1 - 25% of the time)

4. How would you describe the type of pain?

- | | | | |
|--|--------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Tingly | <input type="checkbox"/> Numb | <input type="checkbox"/> Sharp with motion |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stiff | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Achy | <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Electric like with motion | <input type="checkbox"/> Other _____ | | |

5. How are your symptoms changing with time?

- Getting Worse
- Not Changing
- Getting Better

6. Using a scale from 0-10 (10 being the worst), please circle how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10

7. How much has the problem interfered with your work?

- Not at all
- A little bit
- Moderately
- Quite a Bit
- Extremely

8. How much has the problem interfered with your social activities?

- Not at all
- A little bit
- Moderately
- Quite a Bit
- Extremely

9. Who else have you seen for your problem?

- | | | |
|--|---|---|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER Physician | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> No One |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Other _____ |

10. How long have you had this problem? _____
11. How do you think your problem began? _____
12. Do you consider this problem to be severe? Yes Yes, at times No
13. What aggravates your problem? _____
14. What makes your problem better? _____
15. What concerns you the most about your problem: what does it prevent you from doing?
16. How would you rate your overall health?
 Excellent Very Good Good Fair Poor
17. What type of exercise do you do?
 Strenuous Moderate Light None
18. Indicate if you have any immediate family members with any of the following?
 Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS
19. What treatment have you already received for your condition?
 Medications Surgery Physical Therapy Chiropractic Care
 None Other _____

Please provide the Name and addresses of other doctor(s) who have treated you for your condition

20. Please list name, frequency and dosage of any medications and/or supplements you are currently taking
- | | Start Date | | Start Date |
|----------|------------|----------|------------|
| 1. _____ | _____ | 5. _____ | _____ |
| 2. _____ | _____ | 6. _____ | _____ |
| 3. _____ | _____ | 7. _____ | _____ |
| 4. _____ | _____ | 8. _____ | _____ |
21. Date of Last: Spinal Exam: _____ Spinal X-Ray: _____ Blood Test: _____
Dental X-Ray: _____ Chest X-Ray: _____ Urine Test: _____
Physical Exam: _____ MRI, C-Scan, Bone Scan: _____

22. Please mark "Yes" or "No" to indicate if you have had any of the following

AIDS / HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	_____
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No				_____

23. Indicate "Yes" or "No" if you have the following emotional stress and, using a scale from 0-10 (10 being the worst), please circle the severity of the stress.

Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	0	1	2	3	4	5	6	7	8	9	10
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	0	1	2	3	4	5	6	7	8	9	10
High Stress Work Environment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	0	1	2	3	4	5	6	7	8	9	10
High Stress Home Environment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	0	1	2	3	4	5	6	7	8	9	10

24. What are your past and current habits?

Tobacco Never been a Tobacco User Former Tobacco User Current Tobacco User *(continue section)*
 I smoke ____ pack(s) a day / week I chew ____ can(s) a day / week I vape ____ oz of ____ mg juice a week

Using a scale from 0-10 (10 being the worst), please circle what your level of interest in quitting is?

0 1 2 3 4 5 6 7 8 9 10 I am using a quitting method

Alcohol I drink ____ drinks(s) a day / week I am a social drinker I do not drink alcohol

Coffee / Caffeine Drinks I drink ____ drinks(s) a day / week I do not drink caffeine

25. Are you pregnant? No Yes Due Date _____

26. What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer Work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the Phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

27. What activities do you do outside of work? _____

28. Have you ever been hospitalized? Yes No

If yes, why? _____

29. Please mark "Yes" or "No" to indicate if you have had any of the following during your childhood years

Did you have any childhood illnesses? Yes No _____

Were you vaccinated? Yes No _____

Did you have any falls from a height of over 3 feet? *i.e. crib, bunk, tree* Yes No _____

Did you play sports? Yes No _____

Was there any prolonged use of medicine such as antibiotics or inhaler? Yes No _____

Did you suffer from any form of abuse? Yes No _____

Did you take / use illegal drugs? Yes No _____

Were you involved in any accidents? Yes No _____

Were you under regular Chiropractic care? Yes No _____

30. Please list anything else that is pertinent to you visit today _____

Print Patient Name _____

DOB _____

Signature of Patient, Parent, Guardian or Personal Representative _____

Date _____

HIPPA Privacy

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Wellness One, we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a specific form please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

Jayme L. Gawith, D.C.
(316) 636-9393

If you would like further information about our privacy policies and practices please contact:

Jan Pitz
(316) 636-9393

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of January 31, 2012. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Signature

Date

If you are a minor, or if you are being represented by another party

Printed Personal Representative

Relationship to Patient

Personal Representative Signature

Date