**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: ____________

Cell Phone: ____________ Home Phone: ____________ Work Phone: ____________

Best Time and Primary Number to reach you: ______________________________

Would you like to receive text message reminders for your appointments? ☐ Yes ☐ No

E-Mail: ______________________________

Would you like to receive email reminders for your appointments? ☐ Yes ☐ No

Would you like to be included in in our Monthly Health and Wellness email newsletter? ☐ Yes ☐ No

Sign-In: For privacy and security, Wellness One uses digital patient sign in. Your sign-in will be set as your phone number, Please select which number you would like us to use: ☐ Cell ☐ Home ☐ Work

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: ____________

Who referred you to 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): ______________________________

## *DEMOGRAPHICS*

*Completion of this section is optional*

Primary 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 ____________

## INSURANCE INFORMATION

*Please fill in the Information for the Primary Insured*

Primary Health Insurance Name: ______________________________

Name: ______________________ Birth Date: ______________ Relationship to Patient: ______________

Secondary Health Insurance Name: ______________________________

Name: ______________________ Birth Date: ______________ Relationship to Patient: ______________

## *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*

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, parent, 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: ______________________ Relationship: ______________ Phone: ______________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

E-Mail: ______________________________

Name: ______________________ Relationship: ______________ Phone: ______________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Email: ______________________________

WELLNESS ONE

## PATIENT HEALTH HISTORY

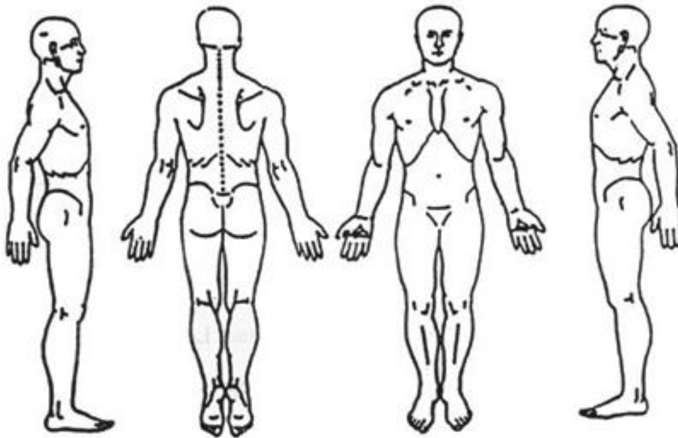
1. Which option best describe your current ideas and values towards health?

| | | |
|---|---|---|
| ☐ | 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?

| | | | |
|---|---|---|---|
| ☐ Sharp | ☐ Tingly | ☐ Numb | ☐ Sharp with motion |
| ☐ Diffuse | ☐ Shooting | ☐ Stiff | ☐ Shooting with motion |
| ☐ Dull | ☐ Achy | ☐ Burning | ☐ Stabbing with motion |
| ☐ Electric like with motion | ☐ 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?

| | | |
|---|---|---|
| ☐ Chiropractor | ☐ Neurologist | ☐ Primary Care Physician |
| ☐ ER Physician | ☐ Orthopedist | ☐ No One |
| ☐ Massage Therapist | ☐ Physical Therapist | ☐ 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 | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | *Rheumatoid Arthritis* | ☐ Yes ☐ No |
| Alcoholism | ☐ Yes ☐ No | Emphysema | ☐ Yes ☐ No | Measles | ☐ Yes ☐ No | *Rheumatic Fever* | ☐ Yes ☐ No |
| Allergy Shots | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No | Migraine Headaches | ☐ Yes ☐ No | *Scarlet Fever* | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Fractures | ☐ Yes ☐ No | Miscarriage | ☐ Yes ☐ No | *Sexually Transmitted Disease* | ☐ Yes ☐ No |
| Anorexia | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Mononucleosis | ☐ Yes ☐ No | *Stroke* | ☐ Yes ☐ No |
| Appendicitis | ☐ Yes ☐ No | Goiter | ☐ Yes ☐ No | Multiple Sclerosis | ☐ Yes ☐ No | *Suicide Attempt* | ☐ Yes ☐ No |
| Arthritis | ☐ Yes ☐ No | Gonorrhea | ☐ Yes ☐ No | Mumps | ☐ Yes ☐ No | *Thyroid Problems* | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Gout | ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No | *Tonsillitis* | ☐ Yes ☐ No |
| Bleeding Disorders | ☐ Yes ☐ No | Heart Disease | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No | *Tuberculosis* | ☐ Yes ☐ No |
| Breast Lump | ☐ Yes ☐ No | Hepatitis | ☐ Yes ☐ No | Parkinson's Disease | ☐ Yes ☐ No | *Tumors, Growths* | ☐ Yes ☐ No |
| Bronchitis | ☐ Yes ☐ No | Hernia | ☐ Yes ☐ No | Pinched Nerve | ☐ Yes ☐ No | *Typhoid Fever* | ☐ Yes ☐ No |
| Bulimia | ☐ Yes ☐ No | Herniated Disk | ☐ Yes ☐ No | Pneumonia | ☐ Yes ☐ No | *Ulcers* | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Herpes | ☐ Yes ☐ No | Polio | ☐ Yes ☐ No | *Vaginal Infections* | ☐ Yes ☐ No |
| Chemical Dependency | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No | Prosthesis | ☐ Yes ☐ No | *Whooping Cough* | ☐ Yes ☐ No |
| Cataracts | ☐ Yes ☐ No | High Cholesterol | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No | *Other* | ________ |
| Chicken Pox | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ 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 | ☐ Yes | ☐ No | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Depression | ☐ Yes | ☐ No | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| High Stress Work Environment | ☐ Yes | ☐ No | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| High Stress Home Environment | ☐ Yes | ☐ 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?

| | | | |
|---|---|---|---|
| ☐ Sit: | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day |
| ☐ Stand: | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day |
| ☐ Computer Work: | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day |
| ☐ On the Phone: | ☐ Most of the day | ☐ Half of the day | ☐ 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