



# The Wellness Way

We don't guess...we test!

Located in the **DYNAMIC** Chiropractic & Wellness Center  
952 S. Park Ave, Fond du Lac, WI 54935  
Ph. (920) 921-9100 | Fax (920) 929-0464  
www.TWWClinics.com

## PLEASE NOTE:

This file must be saved to your desktop before and after completing!

### PATIENT INFORMATION

Date \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_  
SSN \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_ Number of Children \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_ Emergency Contact \_\_\_\_\_  
Emergency Relation \_\_\_\_\_ Emergency Phone \_\_\_\_\_

### REFERRAL INFORMATION

I was referred by \_\_\_\_\_  
How did you hear about the clinic?  
 Advertisement  Newspaper  Community Event  Provider Talk  Family/Friend  Other \_\_\_\_\_

### INSURANCE INFORMATION

#### Primary Insurance Information

Insurance Company Name \_\_\_\_\_ Plan Name \_\_\_\_\_  
Phone # \_\_\_\_\_ Primary ID/Policy \_\_\_\_\_ Primary Group # \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_  
If you are NOT the Policy Holder, what is your relation to the Policy Holder? \_\_\_\_\_  
For verification purposes, what is the Policy Holder's Social Security Number? \_\_\_\_\_

#### Secondary Insurance Information

Insurance Company Name \_\_\_\_\_ Plan Name \_\_\_\_\_  
Phone # \_\_\_\_\_ Secondary ID/Policy \_\_\_\_\_ Secondary Group # \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_  
If you are NOT the Policy Holder, what is your relation to the Policy Holder? \_\_\_\_\_  
For verification purposes, what is the Policy Holder's Social Security Number? \_\_\_\_\_

## EMPLOYER INFORMATION

Employed?  Yes  No Employer Name \_\_\_\_\_

Occupation \_\_\_\_\_

## REASON FOR VISIT

Describe in your own words why you wanted to come for an appointment today:

## PERSONAL HEALTH INFORMATION

### Complaints/Concerns

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
<i>E.g. Headaches</i>	<i>June 2007</i>	<i>4 times per week</i>	<i>Mild / Moderate / Severe</i>
1.			
2.			
3.			
4.			
5.			
6.			
7.			

When was the last time you felt well? \_\_\_\_\_

Did something trigger your health changes?

### **Sleep**

Average number of hours you sleep? \_\_\_\_\_ Do you have trouble falling asleep?  Yes  No

Do you feel rested upon awakening?  Yes  No Do you have problems with insomnia?  Yes  No

Do you snore?  Yes  No Do you use sleeping aids?  Yes  No Explain: \_\_\_\_\_

**Injuries**

Describe your injury and pain:

Pain level on scale of 1 - 10 (10 is excruciating pain) At its best? \_\_\_\_\_ At its worst? \_\_\_\_\_ Now? \_\_\_\_\_

Type of injury \_\_\_\_\_

How did it occur?  Work  Automobile  Fall  Other \_\_\_\_\_

Injury Date \_\_\_\_\_ Have you missed work related to this injury?  Yes  No

Unable to work from (dates) \_\_\_\_\_ to \_\_\_\_\_

Received other treatment for this?  Yes  No Where or by whom? \_\_\_\_\_

X-rays taken?  Yes  No Do you currently receive chiropractic care?  Yes  No

What clinic or chiropractor provides that care? \_\_\_\_\_

Please check the character of your current pain (you may check more than one):

- Sharp
- Stabbing
- Dull
- Aching
- Soreness
- Stiffness
- Weakness
- Throbbing
- Numbness
- Shooting
- Burning
- Tingling

Please rate the degree of you pain between 0-10, 0 being no pain and 10 being unbearable: \_\_\_\_\_

How often are your symptoms present?

- Constant
- Frequent
- Occasional
- Intermittent

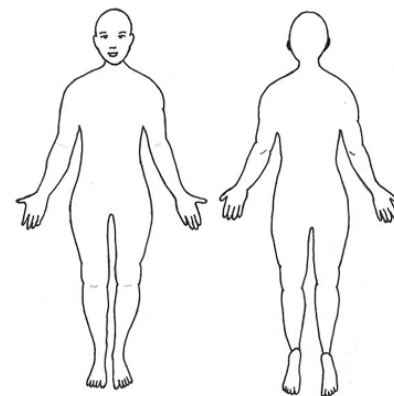
Since your problem began, is the pain? Increasing Decreasing No Change

What activities make symptoms BETTER? Sitting Standing Laying Down

Movement/Exercise Sleep/Rest Other(describe) \_\_\_\_\_

What activities make symptoms WORSE? Sitting Standing Coughing/Sneezing

Movement/Exercise Sleep/Rest Other(describe) \_\_\_\_\_



**Tobacco/Alcohol**

Currently using tobacco?  Yes  No How many years? \_\_\_\_\_ Packs per day \_\_\_\_\_

If yes, what type?  Cigarette  Smokeless  Cigar  Pipe  Patch/Gum

Previous smoking? How many years? \_\_\_\_\_ Packs per day \_\_\_\_\_ Are you exposed to 2nd hand smoke?  Yes  No

If yes, explain: \_\_\_\_\_

How many drinks currently per week? (1 drink=5 oz. wine, 12 oz. beer, and/or 1.5 oz. spirits)

- None
- 1 to 3
- 4 to 6
- 7 to 10
- More than 10

Previous alcohol intake?  Yes  No If yes, was it:  Mild  Moderate  High

**Allergies**

I am allergic to the following medications:

--

I am allergic to the following foods or supplements:

--

Please list your symptoms/reactions to the above medications and/or foods:

--

**Medications and Supplements**

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals, and other nutritional supplements that you are currently taking.

Supplement Name	Dosage

## Health History

Have you ever had any of the following:

Illnesses	Yes	No
Chicken Pox		
Measles		
Mumps		
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, convulsions		
Gallstones		
Gout		
Heart attack/Angina		
Heart failure		
Hepatitis		
High Blood Pressure		
Irritable bowel		
Kidney stones		
Mononucleosis		
Pneumonia		
Rheumatic fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Other (describe)		
Injuries	Yes	No
Head Injury		
Neck Injury		
Back Injury		
Fracture		
Other (describe)		

Diagnostic Studies	Yes	No	Date Performed
Chest X-ray			
Mammogram			
EKG			
Colonoscopy			
Upper GI Series			
Barium Enema			
CAT scan of abdomen			
CAT scan of brain			
CAT scan of spine			
Liver scan			
Bone scan			
Neck X-rays			
Back X-rays			
MRI			
Bone Density Test			
Blood Tests			
Other (describe)			
Operations	Yes	No	
Tonsillectomy			
Tubes in Ears			
Appendectomy			
Gall Bladder			
Hernia			
Hysterectomy			
Dental Surgery			
Other (describe)			
Hospitalizations			
When	For What Reason		

**Women Specific**

Check the box if yes and provide number.

- Pregnancies \_\_\_\_\_
- Miscarriage \_\_\_\_\_
- Living Children \_\_\_\_\_
- Abortion \_\_\_\_\_
- Cesarean \_\_\_\_\_
- Vaginal Delivery \_\_\_\_\_
- Postpartum Depression \_\_\_\_\_
- Toxemia \_\_\_\_\_
- Baby Over 8 Pounds \_\_\_\_\_
- Gestational Diabetes \_\_\_\_\_

Menstrual History

Age At 1st Period \_\_\_\_\_ Menses Frequency \_\_\_\_\_ Length \_\_\_\_\_

Painful?  Yes  No Clotting?  Yes  No Have you ever missed your period?  Yes  No

For how long? \_\_\_\_\_ Are you menopausal?  Yes  No Age At Menopause \_\_\_\_\_

Last Menstrual Period \_\_\_\_\_

Do you take any hormone contraception?  Birth Control Pill  Patch  Nuva Ring

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to The Wellness Way Fond du Lac/Dynamic Chiropractic. I authorize The Wellness Way Fond du Lac/Dynamic Chiropractic and its staff to examine and treat my condition as the practitioners see fit. I hereby authorize The Wellness Way Fond du Lac/Dynamic Chiropractic to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that there is a **72 business hour cancellation policy** for new patient and consultation appointments. Failure to comply with the cancellation policy may result in additional charges. A \$25 fee will be applied to all NSF checks. By clicking the submit button below, I agree to the financial policy described above and will adhere to all of its practices.

Please email this completed form to [dynamic@twwclinics.com](mailto:dynamic@twwclinics.com).

By typing or signing your name below on the signature line, you are agreeing to all of the paragraph above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Thank you!