The Wellness Way Waukesha

628 W. Moreland Blvd., Waukesha WI 53188

Phone: (262) 650-0701

Patient Information:

Date		SSN		Birthday	
First Name		Middle Name		Last Name	
Sex	◯ Male ◯ Female	Height		Weight	
Married/Civil Union:		Spouse Name		# of Children	
Home #		Cell #		Work #	
Address					
City		State		Zip	
Emergency Contact		Emergency Relation		Emergency Phone	
Email					

Patient Social

Alcohol:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Caffeine:	◯ Daily ◯ Weekly ◯ Occasionaly	◯ Never
Diet Food Products:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Drugs:	◯ Daily ◯ Weekly ◯ Occasionaly	◯ Never
OTC Stimulants:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Exercise:	◯ Daily ◯ Weekly ◯ Occasionaly	◯ Never
Homemade Food:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Processed:	◯ Daily ◯ Weekly ◯ Occasionaly	◯ Never
Soft Drinks:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Tobacco:	◯ Daily ◯ Weekly ◯ Occasionaly	◯ Never
Water:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never			

Referral Information:

Referring Physician:		Referred Patient:		Referred by	
Advertisement:	◯ Yes ◯ No	Advertisement:			
Referred Directory:	◯ Yes ◯ No	Referred Directory:			

Employer Information:

Employed:		Employer Name			
Employer Address:					
Employer City:		Employer State:		Employer Zip:	
Occupation:		Work Supervisor:		Supervisor #:	
Work Duties:					

Reason for this Visit:

Describe the reason for this visit?

When did this concern begin? _____ Has this concern: ○ Gotten Worse ○ Stayed Constant ○ Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ○ Yes ○ No

Briefly Explain: _____

Have you seen other doctor's for this concern? ○ Yes ○ No Doctor's name: _____

Type of Treatment: _____

Complaint Information:

Injury Occurred: ○ Work ○ Automobile ○ Third-Party ○ Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Interfere w/ Activities: ○ Yes ○ No Affected Sleep: ○ Yes ○ No Frequency: _____

Missed Work: ○ Yes ○ No Unable to Work from: _____ Unable to Work Until: _____

Affected Appetite: ○ Yes ○ No Explain: _____

Reduced Work: ○ Yes ○ No Explain: _____

Does it Worsen: ○ Yes ○ No Explain: _____

Weather Affects it: ○ Yes ○ No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ○ Yes ○ No Explain: _____

X-rays Taken: ○ Yes ○ No Explain: _____

Pain level Rating - Scale 1 to 10: At its best: ____ At its Worst: ____ Current Level: ____

Same Condition Before: ○ Yes ○ No Date: _____ Practitioner: _____

For Women Only:

Are you pregnant? ○ Yes ○ No Are you taking birth control? ○ Yes ○ No Do you have irregular cycles? ○ Yes ○ No

Are you nursing? ○ Yes ○ No Do you experience painful periods? ○ Yes ○ No Do you have breast implants? ○ Yes ○ No

Insurance Information:

Payment Name _____ Primary Phone # _____ Primary ID/Policy _____

Payment Address _____

Payment City _____ Payment State _____ Payment Zip _____

Primary Group # _____ Primary Name _____ Primary DOB _____

Secondary Name _____ Secondary Phone # _____ Secondary ID/Policy _____

Secondary Address _____

Secondary City _____ Secondary State _____ Secondary Zip _____

Secondary Group # _____ Secondary Name _____ Secondary DOB _____

Claim # _____ Claim Contact _____ Claim # _____

Attorney Name _____ Attorney Phone # _____

Personal Health History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ◯ Yes ◯ No Date: _____ Condition(s) treated: _____

Chance Pregnant: ◯ Yes ◯ No Planning: ◯ Yes ◯ No

Medications: _____

Supplements: _____

Personal Incident History:

Broken Bones: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Sprains/Strains: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Hospitalized: ◯ Yes ◯ No Explain: _____

Surgery: ◯ Yes ◯ No Explain: _____

Auto Accident: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Struck Unconscious: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Eating Disorder: ◯ Yes ◯ No Explain: _____

Stroke: ◯ Yes ◯ No Explain: _____

Health Checklist:

- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Disease
- [ ] Back Pain
- [ ] Bleeding Disorders
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Cataracts
- [ ] Chest Pain
- [ ] CHF
- [ ] Cold Extremities
- [ ] Constipation
- [ ] COPD/emphysema
- [ ] Cramps
- [ ] CVA (stroke/TIA)
- [ ] Dementia/Alzheimer's
- [ ] Depression
- [ ] Diabetes
- [ ] Diagnosed emotional/mental
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Menstruation
- [ ] Eye Pain or Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Gallbladder disease/stones
- [ ] Glaucoma
- [ ] Gout
- [ ] Headache
- [ ] Hemorrhoids
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Irregular Heart Beat
- [ ] Irregular Menstrual Cycle
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Liver disease/cirrhosis
- [ ] Loss of Balance
- [ ] Loss of Memory
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Lung disease
- [ ] Macular Degeneration
- [ ] Migraines
- [ ] Nosebleeds
- [ ] Pacemaker
- [ ] Parkinson's
- [ ] Polio
- [ ] Poor Posture
- [ ] Prostate Trouble
- [ ] Retinal Disease
- [ ] Sciatica
- [ ] Seizures
- [ ] Shortness of Breath
- [ ] Sinus Infection
- [ ] Skin Sensitivity
- [ ] Sleep Problems/Insomnia
- [ ] Smoked
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of Ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other

_____

Have you had any of these Cardiovascular Diseases? Please select all that apply.

- [ ] Myocardial infarction
- [ ] Hypertension
- [ ] Hypercholesterolemia
- [ ] Bypass surgery
- [ ] Coronary artery disease

Do you have Diabetes? If so what type?

- ○ Type I
- ○ Type II
- ○ Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

- [ ] Ulcers
- [ ] Reflux
- [ ] IBS

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 Clinics. I authorize The Wellness Way and its staff to examine and treat my condition as the practitioners see fit. I hereby authorize The Wellness Way 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 signing below, I agree to the financial policy described above and will adhere to all of its practices.

Signature _____ Date: _____

Thank you for taking the time to complete this form!
Simply save this file to your computer and send as an email attachment to the following email address: waukesha@thewellnesswayclinics.com