EXEMPLIFY
HEALTH CENTER
A Wellness Way Affiliate

Exemplify Heath Center
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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 puposes, 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 puposes, 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
E.g. Headaches	*June 2007*	*4 times per week*	*Mild / Moderate / Severe*
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? _____

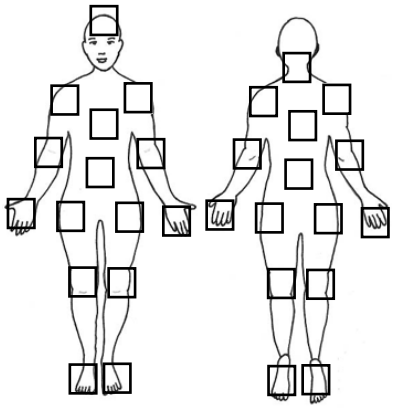
X-rays taken? ○ Yes ○ No Do you currently receive chiropractic care? ○ Yes ○ No

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 – Yorkville. I authorize The Wellness Way – Yorkville and its staff to examine and treat my condition as the practitioners see fit. I hereby authorize The Wellness Way – Yorkville 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 **yorkville@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!