



WESTCHASE WELLNESS
CHIROPRACTIC CENTER

Westchase Wellness Chiropractic Center

Patient Information

Name: _____ Occupation: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell: _____
 Social Security Number: _____ Birth Date: _____ E-mail: _____
 Gender: ___ Male ___ Female Circle One: Married Single Widowed Divorced Separated
 Referred By: _____

Current Health Condition

Purpose of this Appointment: _____

 Health Conditions and Complaints: (please list in order of severity) _____

 Medications: (list meds by name, mg's, what for, how long. Don't forget birth control, aspirin, pain meds) _____

 Surgeries: (list surgeries, operations, plastic surgery, and trauma. Please date when they occurred) _____

 Allergies: (please list food, environmental, chemical, and drug) _____

 Supplements or Herbs: (list name and why you're taking them) _____

Family Information

Name and # of Emergency Contact: _____

Blood Type:

A AB B O - +

Past Health History

Previous Chiropractic Care: ___ None ___ Yes

If yes, what is the doctor's name and approximate date of last visit:

My signature confirms that the above information is true.

Signature: _____ Date: _____



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Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- Anemia
- Appendicitis
- Arthritis
- Asthma
- Bronchitis
- Cancer
- Cataracts
- Chicken Pox
- Diabetes

- Eczema
- Epilepsy
- Goiter
- Gout
- Heart Disease
- Hepatitis
- Influenza
- Lumbago
- Measles
- Mental disorders

- Mumps
- Osteoporosis
- Pleurisy
- Pneumonia
- Polio
- Rheumatic Fever
- Small Pox
- Thyroid
- Tuberculosis
- Tumors/ Growths
- Whooping Cough

INTAKE

- Coffee
- Tea
- Sodas
- Alcohol
- Cigarettes
- White Sugar

Are you HIV positive? Yes No

MUSCULO-SKELETAL

- Neck Pain
- Pain Between Shoulders
- Low Back Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness
- Fractures
- Hernia
- Herniated Disk/ Pinched Nerves
- Multiple Sclerosis
- Scoliosis

GENERAL

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches/ Migraines

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine
- Urinary Tract Infections

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate Problems
- Infertility
- Hysterectomy
- Sexual Dysfunction

NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Tonsillitis
- Ear Aches
- Hearing Difficulty
- Sinus Congestion

FAMILY HISTORY

The following members have the same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

FEMALES ONLY

When was your last period?

Are you pregnant?

- Yes No Not Sure

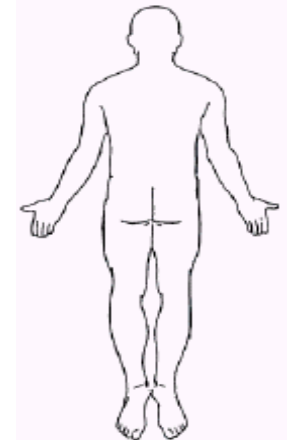
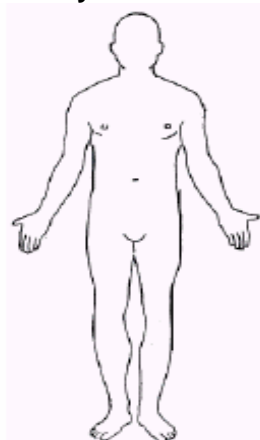
CARDIOVASCULAR

- Chest Pain
- Short of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Pacemaker
- Lung Problems /Congestion
- Varicose Veins
- Ankle Swelling
- Stroke
- High Cholesterol

GASTRO-INTESTINAL

- Poor Appetite
- Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gallbladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Kidney Disease
- Heartburn
- Black/Bloody Stool
- Colitis

Please outline on the diagram the area of your discomfort



Westchase Wellness Chiropractic Center Health Care Authorization Form

Patient's Name: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **Westchase Wellness Chiropractic Center** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

Open Room Authorization

_____ (Initial) I give **Westchase Wellness Chiropractic Center** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of my care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

Authorization of Treatment

_____ (Initial) I hereby authorize **Westchase Wellness Chiropractic Center** to treat my condition, as they deem appropriate through the use of chiropractic manipulation, and physical modalities. **Westchase Wellness Chiropractic Center**, including its doctors and staff, will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. I agree that I am ultimately responsible for all bills incurred by me at this office.

Permission & Authorization Regarding the Use of Kinesiological Reflex Testing

_____ (Initial) I specifically authorize the natural health practitioners at **Westchase Wellness Chiropractic Center** to perform a **Kinesiological Reflex Testing** health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment or "cure" of any disease.**

I understand that **Kinesiological Reflex Testing** is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs. I also understand that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that **Kinesiological Reflex Testing** is not a method for "diagnosing" or "treating" any disease including cancer, AIDS, infections, or other medical conditions, and that these are not being testing for or treated.

No promise or guarantee has been made regarding the results of **Kinesiological Reflex Testing** or any natural health, nutritional or dietary programs recommended, but rather I understand that Kinesiological Reflex Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

Patient/Guardian Signature

Date

Authorization of Assignment

To Westchase Wellness Chiropractic Center,

In consideration of you undertaking to treat me, I agree to the following:

Authorization to Release Information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you or your staff, and hereby release you of any consequence thereof.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payments to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth under pertinent date below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds within a 60 day period from the time of service (whether it be all or part of what is due), I personally owe you and agree to pay in a current manner.

Authorization to Pay Directly to Doctor

To: _____
(Name of Attorney and/or Insurance Company)

In consideration of the chiropractic services rendered and to be rendered by the doctor(s), I authorize and direct the payment to Westchase Wellness Chiropractic Center of any sum I now or hereafter owe them by myself, my attorney, out of proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for their services or otherwise obligated to make payment to me or them based in whole or in part upon the charges made for their services.

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at Westchase Wellness Chiropractic Center and that I have been advised that the doctor(s) providing services is/are willing to wait a maximum of 60 days from the time of service incurred for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

1. that there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or
2. if a liability claim exists, and my attorney refuses to agree to protect the interests of the doctor(s) or if I have not engaged the services of an attorney;

Then payment of services rendered by the doctor(s) at Westchase Wellness Chiropractic Center will be made on a current basis and my bill paid in full as soon as the liability claim is settled or the passage of 6 months from my last treatment, whichever occurs first.

Dated: The _____ day of _____ 20_____

Patient's Signature: _____

Witness: _____

Westchase Wellness Chiropractic Center Health Overview

Smoking: Do you smoke? _____ If yes, how much? _____ How long have you smoked? _____

Drug Use: (*CONFIDENTIAL*) Do you use any recreational drugs? _____ (if yes, circle marijuana, cocaine, heroin, uppers, downers) Others: _____ How often? _____

Stress: Please rate your current stress level on a scale of 1 to 10, 10 being the highest stress: _____

What are the main reasons for your stress? _____

How do you reduce stress? _____

Sleep: How is your sleep? (CIRCLE: restful, restless, hard to fall asleep, wake up often, bad dreams.)

What time do you go to sleep? _____ Number of hours of sleep per night? _____

Digestion: (CIRCLE: good, adequate, poor, acid reflux, burping, bloating, burning, pain, cramping)

Other Complaints: _____

Urination: (CIRCLE: every 2-3 hours, too frequent, sense of urgency, burning, dribbling, urinate at night)

Other Complaints: _____

Bowels: How many bowel movements per day _____ per week _____ **Amount:** normal, too large, too small

Consistency: normal, hard, soft, diarrhea **Color:** tan, brown, black, green **Other:** gas, mucus, smell **Other Complaints:** _____

Exercise: Do you exercise? _____ What kind of exercise? _____

How often? _____ For how long of a time? _____

Sunlight: How many hours of sunlight do you get daily? _____ weekly? _____

How many hours daily do you spend under fluorescent lights? _____

Electromagnetic pollution: How many hours do you spend daily Watching TV? _____

Working on a computer? _____ Talking on the phone? _____ Wearing a watch? _____

Wearing a hearing aid? _____ Riding in a car? _____ Do you live next to power lines? _____

Diet: How many times a day do you eat? _____ How often do you eat out? _____

Drinking: What kind of water do you drink? CIRCLE: tap, filtered, spring, reverse osmosis, distilled

Circle beverages you drink and how many times per day (d) or per week (w) you drink them:

Milk _____ coffee _____ tea _____ herbal tea _____ soda _____ beer _____ wine _____ liquor _____

***Woman Only:** Are you pregnant? _____ Are you breastfeeding? _____ Do you have monthly periods? _____

Last period date: _____ Are you going through menopause _____ Have your periods stopped _____

Menstrual Cycle: Number of days of flow _____ CIRCLE: heavy, light, spotting, normal

Circle: cramping, bloating, weakness, mood swings, cravings, pain, bright blood, dark clotty blood

Other menstrual complaints: _____

My signature confirms that the above information is true.

Signature: _____ **Date:** _____



Westchase Wellness Chiropractic Center
Pediatric Form
(only fill out if patient is 5 years old or under)

Prenatal History:

Were you taking prenatal vitamins while pregnant? _____ When did you begin taking them? _____

Did you take any medications while pregnant? _____ Why? _____

How stressful would you rate your pregnancy on a scale of 1-10 (10 being the most stressful)? _____

Birth History:

How long were you pregnant? _____ weeks

Who delivered your baby? Circle: obstetrician, midwife, Other: _____

How was your baby delivered? Circle: vaginal, c-section, forceps, vacuum, other: _____

Did you receive any meds during labor? Circle: induced (ptocin) pain medication (epidural) Other: _____

What was your baby's APGAR score? 1 2 3 4 5 6 7 8 9 10

Infant or Toddler:

What is the number one complaint today? _____

How long has it been going on? _____

What makes the situation worse? _____

What makes the situation better? _____

***Please circle all that your infant or toddler is having trouble with:

Eyes, Ears, Nose, Throat, Heart, Lungs, Breathing, Gassy, Diarrhea, Constipation, Vomiting, Seizures

Skin, Learning Disorders, Emotional Disorders, Behavioral Disorders, Genetic Disorders

What does your baby's diet consist of? _____

Is there anything else that may be important? _____

Mother's Information:

How many past pregnancies? _____ How many were delivered? _____

Do you take vitamins? _____ What kind? _____

Do you smoke? _____ How many packs per day? _____ How long have you smoked? _____

***If you are breastfeeding continue

Do you drink alcohol? _____ How much? _____ How often? _____

Do you drink soft drinks? _____ How many per day? _____

Do you drink coffee? _____ How many per day? _____

Do you consume dairy products? _____ How much per day? _____

What food do you eat regularly? _____

My signature confirms that the above information is true.

Legal Guardian Signature: _____ **Date:** _____

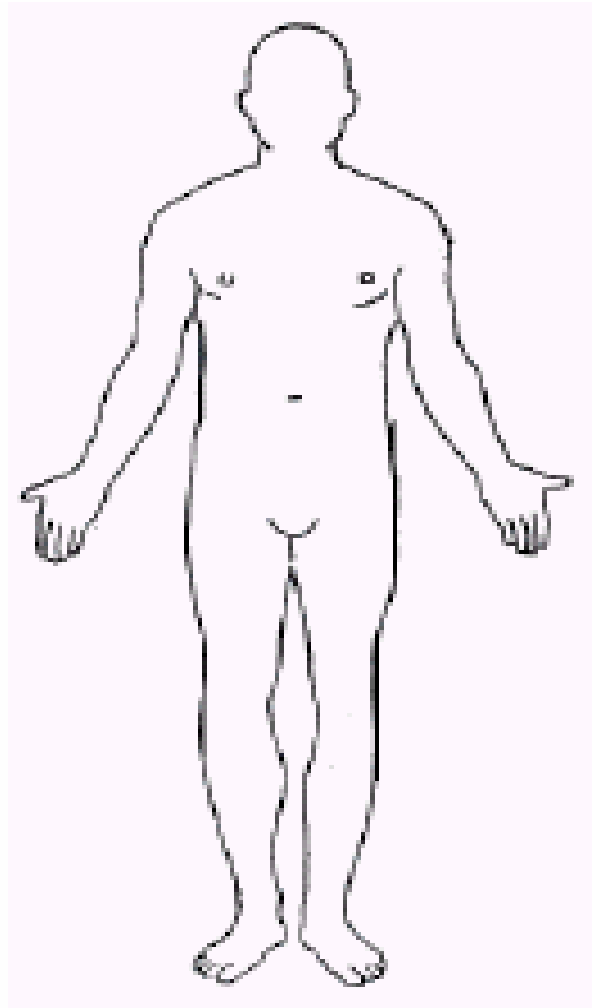
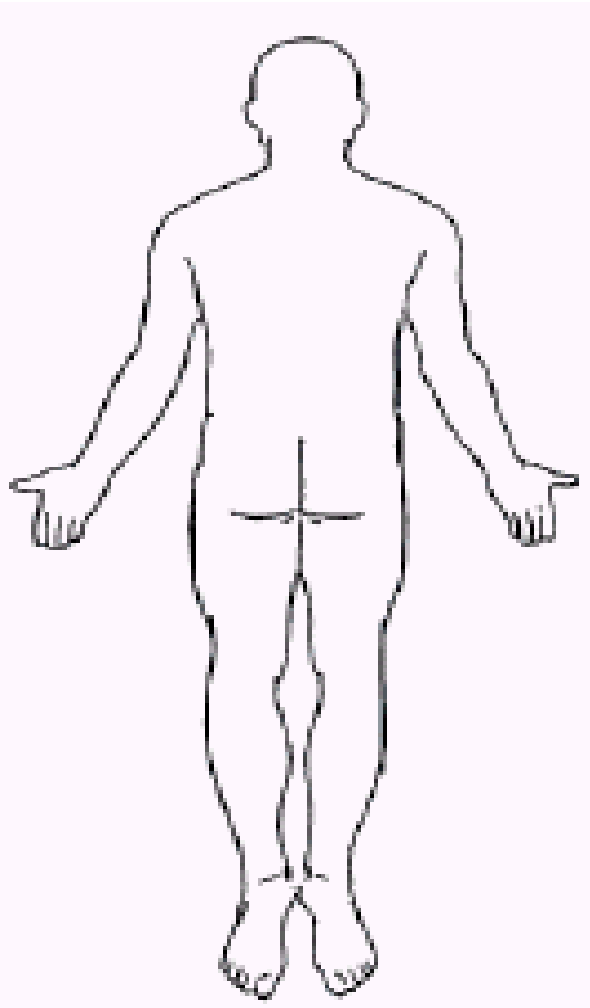


Westchase Wellness Chiropractic Center

Scar/Trauma Chart

Name: _____

Date: _____



Directions

All Scars: Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, vasectomies, all injection sites, old burn areas, etc.

All Trauma Areas: Please put a red X where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects, such as a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury: Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988.")

Toxicity Questionnaire

Please rate each of the following based on your health profile based on the last 90 days.

0= Rarely or never experience the symptom 1= Occasionally experience but effect is not severe
 2= Occasionally experience but effect is severe 3= Frequently experience and effect is not severe
 4= Frequently experience and effect is severe

Digestive:

Nausea or Vomiting 0 1 2 3 4
 Diarrhea 0 1 2 3 4
 Constipation 0 1 2 3 4
 Gas, Belch, Bloating 0 1 2 3 4
 Heartburn/Reflux 0 1 2 3 4
 Hemorrhoids 0 1 2 3 4
Total: _____

Heart:

Shortness of Breath 0 1 2 3 4
 Skipped Heartbeat 0 1 2 3 4
 Rapid Heartbeats 0 1 2 3 4
 High/Low Blood Pressure 0 1 2 3 4
 Chest Pain/Tightness 0 1 2 3 4
Total: _____

Emotions:

Mood Swings 0 1 2 3 4
 Anxiety/Fear/Nervous 0 1 2 3 4
 Anger/Irritability 0 1 2 3 4
 Depression 0 1 2 3 4
 Sense of Despair 0 1 2 3 4
Total: _____

Energy:

Fatigue/Tired 0 1 2 3 4
 Sluggishness 0 1 2 3 4
 Hyperactivity 0 1 2 3 4
 Restlessness 0 1 2 3 4
 Brain Fog 0 1 2 3 4
 Irritable if Miss Meals 0 1 2 3 4
Total: _____

Weight:

Cravings 0 1 2 3 4
 Overweight 0 1 2 3 4
 Compulsive Eating 0 1 2 3 4
 Water Retention 0 1 2 3 4
 Underweight 0 1 2 3 4
Total: _____

Sleep:

Can't fall asleep 0 1 2 3 4
 Wake up often 0 1 2 3 4
 Nighttime urination 0 1 2 3 4
 Wake up tired 0 1 2 3 4
 Bad dreams 0 1 2 3 4
Total: _____

Skin:

Flushing 0 1 2 3 4
 Acne 0 1 2 3 4
 Dry skin 0 1 2 3 4
 Oily skin 0 1 2 3 4
 Hives, rashes 0 1 2 3 4
 Eczema/Psoriasis 0 1 2 3 4
 Hair loss 0 1 2 3 4
Total: _____

Head / Eyes:

Headaches 0 1 2 3 4
 Faintness 0 1 2 3 4
 Dizziness 0 1 2 3 4
 Pressure 0 1 2 3 4
 Blurred vision 0 1 2 3 4
Total: _____

Allergies:

Watery/Itchy eyes 0 1 2 3 4
 Runny nose/drainage 0 1 2 3 4
 Sneezing 0 1 2 3 4
 Itchy throat 0 1 2 3 4
 Itchy skin 0 1 2 3 4
Total: _____

Immune:

Frequent illness 0 1 2 3 4
 Fever 0 1 2 3 4
 Sore throat 0 1 2 3 4
 Leaky bladder 0 1 2 3 4
 Genital itch/discharge 0 1 2 3 4
Total: _____

Ears:

Itchy ears 0 1 2 3 4
 Earaches/infections 0 1 2 3 4
 Fluid in ears 0 1 2 3 4
 Ringing in ears 0 1 2 3 4
 Hearing loss 0 1 2 3 4
Total: _____

Sinus / Nose:

Stuffy nose 0 1 2 3 4
 Sinus headache 0 1 2 3 4
 Excessive mucous 0 1 2 3 4
 Sinus infections 0 1 2 3 4
 Nose bleeds 0 1 2 3 4
Total: _____

Mouth / Throat:

Dry mouth/thirsty 0 1 2 3 4
 Post nasal drip 0 1 2 3 4
 Swollen tongue, gums, lip 0 1 2 3 4
 Canker sores 0 1 2 3 4
 Cold Sores 0 1 2 3 4
 Gagging/clearing throat 0 1 2 3 4
 Tooth pain 0 1 2 3 4
Total: _____

Lungs:

Chest congestion 0 1 2 3 4
 Asthma 0 1 2 3 4
 Coughing 0 1 2 3 4
 Difficulty breathing 0 1 2 3 4
Total: _____

Joints / Muscles/ Bone:

Arthritis 0 1 2 3 4
 Osteopenia/osteoporosis 0 1 2 3 4
 Stiffness/limited moving 0 1 2 3 4
 Pain/aches in muscles 0 1 2 3 4
 Pain/aches in joints 0 1 2 3 4
 Cramping 0 1 2 3 4
Total: _____

Name: _____ Date: _____ TOTAL FOR PAGE= _____

