File#: _____

Date: _____

Results Chiropractic and Wellness

Jared Wannenwetsch, D.C.

Dr. Jared and staff would like to welcome you to our office and want to provide you the best care. As such, upon completion of a thorough history and physical examination we will determine if you are a good candidate for chiropractic care. If we believe your condition will not respond to chiropractic care we will refer you to the appropriate health care provider.

Patient Information

Name: (Last, First)_____ D.O.B: _____ /____ /_____

Age: _____ Sex: _____ Height: _____ Weight: _____ (lbs) Race: _____

Marital Status: □ Single □ Married □ Divorced □ Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email address: _____

Employment Information

Employment Status: □ Employed □ Unemployed □ Student □ Retired □ Other

Employer: _____ Occupation: _____

Responsible Party Information (if over age 18, please indicate self)

Name (if other than self): _____ Relation to Patient: _____

Address: _____ City:_____ State:_____ Zip: _____

Responsible Party's Phone #: _____

Emergency Contact

Name: _____ Relation to Patient: _____

Phone #: _____

Is your injury related to any of the following?

□ Auto Accident (State of Accident) _____ □ Employment □ Fall □ Lifting

If employment related, has the employer been notified? □ Yes □ No

How were you referred to our office?

□By a patient □ By a doctor □ Drive by □ Social Media □ Other _____

Please print the name of your source: _____

ACCEPTANCE AS A PATIENT

I understand and agree that the doctor(s) of Results Chiropractic and Wellness have the right to refuse to accept me as a patient at any time before treatment begins. The history and physical examination are not considered treatment, but they are part of the evaluation process so that the doctor can determine whether to accept me as a patient.

Signature: _____ DATE: _____

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Patient Medical History Checklist (indicate if you have had any of the following)

Chest pain?	□Yes □No	Vertigo (dizziness)?	□Yes □No
Change in bladder or bowel habits?	□Yes □No	Double vision?	□Yes □No
A sore throat that does not heal?	□Yes □No	Visual disturbances?	□Yes □No
Unusual bleeding or discharge?	□Yes □No	Nausea or vomiting?	□Yes □No
Thickening in breasts or elsewhere?	□Yes □No	Slurred speech?	□Yes □No
Indigestion of difficulty swallowing?	□Yes □No	Ringing in your ears?	□Yes □No
A change in a wart or a mole?	□Yes □No	Pass out easily (faint)?	□Yes □No
A nagging cough or hoarseness?	□Yes □No	Get dizzy when changing positions?	□Yes□No
Headaches for hours or days?	□Yes □No	Have had cancer?	□Yes □No
Blurred vision?	□Yes □No	Pain wakes you from a sound sleep?	□Yes□No
Night sweats?	□Yes □No	Losing weight without trying?	□Yes □No
Pain in neck, jaw or face?	□Yes □No	Loss of bladder or bowel control?	□Yes □No
Drooping eyelid or change in pupils?	□Yes □No	Coughing up blood?	□Yes □No
Family history of stroke?	□Yes □No	Blood in stool or urine?	□Yes □No

Lost consciousness or double vision recently? □Yes □No

Are you seeing a doctor for any other reason (if so describe)? _____

_____

List all prescription/otc medication: _____

_____

FEMALE ONLY: Onset date last menses _____ Do you take birth control? □Yes □No

Social History

Do you smoke? □Yes □No If yes, packs per day? _____

Do you drink? □Yes □No If yes, drinks per (circle one) day / week?_____

Family History

Did your mother or father have any of these conditions? Put and **M** for mother and **F** for father.

_____ High Blood Pressure	_____ Asthma	_____ Ulcer/Stomach Problems	_____ Thyroid Disease
_____ Heart Attack	_____ Diabetes	_____ Stroke	_____ Poor Circulation
_____ Emphysema	_____ Cancer	_____ Arthritis-Rheumatism	_____ Kidney disease
_____ Seizures/Convulsions	_____ Pacemaker	_____ Mental Illness	_____ Osteoporosis
_____ HIV positive			

Comments:

_____

_____

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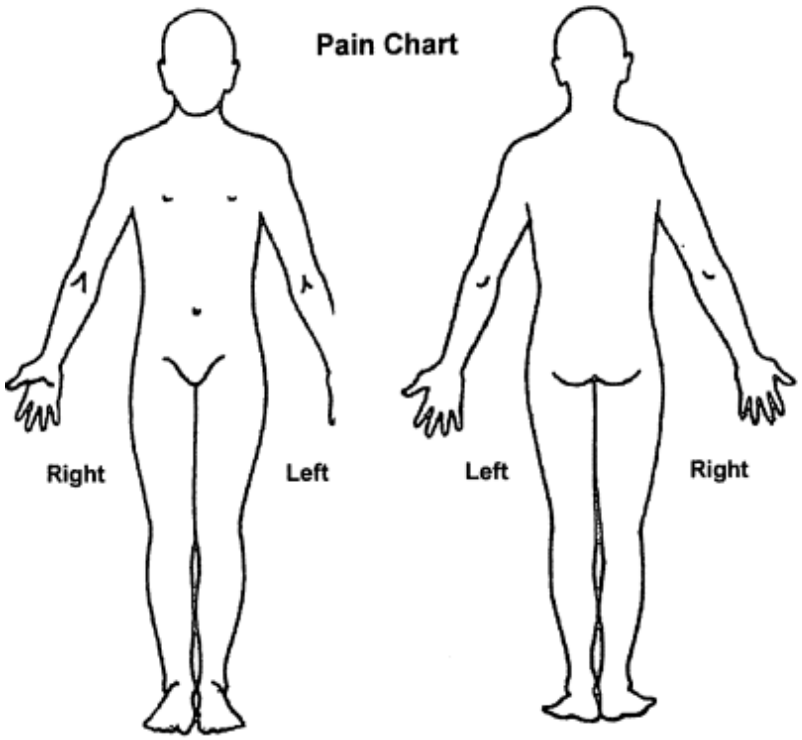
Pain Diagram

Mark the areas on the body drawing where you feel the described sensations. Use the symbols provided. Mark all areas of pain radiation and include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - -	00000000	XXXXXXXX	********	/ / / / /
- - - - - - -	00000000	XXXXXXXX	********	/ / / / /
- - - - - - -	00000000	XXXXXXXX	********	/ / / / /
- - - - - - -	00000000	XXXXXXXX	********	/ / / / /



Please mark on the pain scale from 0 to 10 the pain you feel with this condition, 10 being the worst pain you have felt with this condition.

Pain Scale

Neck-Shoulder-Arm Pain
On a scale of 0 to 10.
I rate my discomfort as follows

0 no pain — 10 severe pain

Mid-Back Pain
On a scale of 0 to 10.
I rate my discomfort as follows

0 no pain — 10 severe pain

Lower Back Pain
On a scale of 0 to 10.
I rate my discomfort as follows

0 no pain — 10 severe pain

When and how did the pain start? _____

_____

Is the pain constant, frequent, or intermittent? _____

Has the pain gotten better, worse, or stayed the same? _____

Have you had any other treatment for this condition (what type and results) _____

_____

Do you have any other symptoms you associate with this condition? _____

List any previous surgeries, traumas, major accidents, illnesses… _____

_____

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PROTECTED PATIENT INFORMATION (HIPPA)

I consent to the use and disclosure of my protected health information only for the purpose of providing treatment to me, for purposes related to the payment of services for me, and for this office's general healthcare operations. These may include quality assurance activities, credentialing, business management, etc. Protected health information means any information, including demographic information, that relates to my past, present, or future physical or mental health or condition, the provision of health care to me, and that either identifies me or can reasonably be expected to be used to identify me. I understand that I have the right to request a restriction on the use and disclosure of this information. I understand that I have the right to review the full Notice of Privacies developed by the clinic prior to signing this document. I have the right to revoke consent in writing at any time.

SIGN: _____ DATE: _____

PRINT NAME: _____ DATE: _____

INFORMED CONSENT TO CHIROPRACTIC CARE

-I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

- I further understand that such chiropractic services may be performed by the Results Chiropractic and Wellness Clinic and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Jared Wannenwetsch D.C. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

-I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries and conditions precipitated by such injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure that the physician feels is in my best interests at the time, based upon the facts then known.

-I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician and certify that I comprehend the inherent risks and benefits associated with the aforementioned treatment. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

SIGN: _____ DATE: _____

PRINT NAME: _____ DATE: _____

WITTNESS: _____ DATE: _____