WellnessPlus
1001 Physicians Drive
Charleston, SC 29414
www.WellnessPlusCharleston.com

Confidential Patient Information

Date ____________

First Name: ____________ Last Name: ____________ Initial ______

Major Complaint Information

What is your major complaint(s)? ____________

____

When did this symptom(s) begin? ____________

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe)

RIGHT LEFT RIGHT

Pain Index

B Burning
S Sharp / Stabbing

For example: if you are experiencing moderately severe burning pain in back of your neck, you should note a "B8" on the neck of the illustration.

It this is an injury, describe what happened:

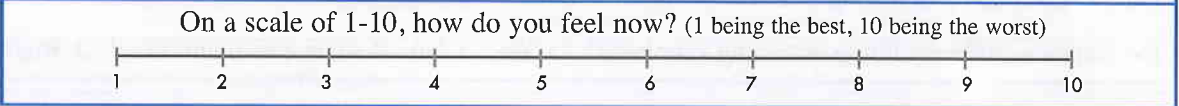
____

____

____

____

On a scale of 1-10, how do you feel now? (1 being the best, 10 being the worst)



Have you experienced these symptoms before? ○ Yes ○ No When? ____________

Theses symptoms developed from? ○ Auto Accident ○ Work-Related ○ Other: ____________

Have you reported this to your: insurance company ○ Yes ○ No employer ○ Yes ○ No

What aggravates this condition? ____________

What decreases the symptoms / pain? ____________

Have you seen another doctor for this condition? ○ Yes ○ No Doctor's Name: ____________

Date consulted: ____________ Diagnosis: ____________

Does this condition interfere with your sleep? ○ Yes ○ No If so, how many times do you wake up in pain per night? ____________

In what position do you sleep? ○ Back ○ Side ○ Stomach

Do you sleep with a pillow? ○ Yes ○ No How many? ____________

Does heat affect the pain? ○ Yes ○ No If so, how? ____________

Does cold affect the pain? ○ Yes ○ No If so, how? ____________

Do you wear a heel lift? ○ Yes ○ No If so, which side? ○ Right ○ Left

Does it cause pain to cough, grunt, or sneeze? ○ Yes ○ No If so, where? ____________

Check those activities below during which you experience difficulty or pain:

❍ Lying on back	❍ Getting in/out of car	❍ Sleeping	❍ Stooping	❍ Standing for periods over one hour
❍ Lying on side with knees bent	❍ Gripping	❍ Pushing	❍ Sitting	❍ Sneezing
❍ Turning over in bed	❍ Climbing	❍ Pulling	❍ Bending forward	❍ Coughing
❍ Lying flat on stomach	❍ Dressing Self	❍ Reaching	❍ Bending backward	❍ Other:____________
	❍ Sexual Activity	❍ Kneeling	❍ Walking	

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

Headaches

Do you have a family history of headaches? ❍ Yes ❍ No Do you get headaches? ❍ Yes ❍ No Frequency __________

Do you experience the following along with your headaches: Pain or cracking in your jaw? ❍ Yes ❍ No

Abnormal blood pressure? ❍ Yes ❍ No ❍ High ❍ Low Nausea, Vomiting or Visual disturbances? ❍ Yes ❍ No

When was your last eye exam by a doctor? ❍ 1 - 6 months ❍ 6 - 12 months ❍ 1 - 2 years ❍ over 2 years Results:_______

Lower Back Pain

Do you ever experience ripping or tearing sensations in you back? ❍ Yes ❍ No If so, where: ____________________

Does pain radiate to the abdomen? ❍ Yes ❍ No

Do you ever have impairment of bowel or urinary function? ❍ Yes ❍ No Explain: ____________________

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) ❍ Hearing ❍ Vision ❍ Balance ❍ Cause ringing in your ears

Do you hear grating sounds? ❍ Yes ❍ No Do you feel pressure or pain behind your eyes? ❍ Yes ❍ No

Do you feel ripping or tearing? ❍ Yes ❍ No Where: ____________________

Do you have difficulty lifting or turning your head? ❍ Yes ❍ No If so, in which direction? ❍ Right ❍ Left ❍ Up ❍ Down

If female, are you pregnant? ❍ Yes ❍ No ❍ Not Sure If yes, what is your due date?:____________

List all medications you are taking now, including over the counter medication. ____________________

____

Are you allergic to any medications? ❍ Yes ❍ No ❍ Not Sure Please list: ____________________

____

Have you ever had any surgeries or hospitalizations? ❍ Yes ❍ No Please list:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:

Have you been x-rayed in the last 12 months? ❍ Yes ❍ No When?: ____________________

Have you ever been seen by a chiropractor before? ❍ Yes ❍ No Please list:

Name of Chiropractor:	Dates:	Name of Chiropractor:	Dates:

Do you have a family physician? ❍ Yes ❍ No Name of physician: ____________ Phone: __________

Address: ____________________

City/State/Zip: ____________________

Additional Complaints

Please check all additional complaints that you have at this time:

❍ Headache	❍ Neck Stiffness	❍ Loss of Consciousness	❍ Cold Feet	❍ Arthritis
❍ Loss of Concentration	❍ Neck Motion Restricted	❍ Irritable	❍ Jaw pain	❍ HIV (Aids)
❍ Eyes Sensitive to Light	❍ Upper Back Pain / Stiffness	❍ Anxiety	❍ Cancer	❍ Other (Please List)
❍ Memory Loss	❍ Mid Back Pain / Stiffness	❍ Depression	❍ Hypertension	______
❍ Heavy Feeling of Head	❍ Lower Back Pain / Stiffness	❍ Insomnia	❍ Diabetes	______
❍ Dizziness	❍ Right / Left Shoulder Pain	❍ Fatigue	❍ Hepatitis	______
❍ Ringing in Ears	❍ Right / Left Arm Pain	❍ Flushed Face	❍ Convulsions	
❍ Loss of Balance	❍ Right / Left Leg Pain	❍ Excess Perspiration	❍ Allergies (Please List)	Please Specify Location:
❍ Loss of Smell	❍ Pins & Needles Arms / Legs	❍ Digestive Trouble	______	❍ Numbness ______
❍ Loss of Taste	❍ Vision Problems	❍ Nausea	______	❍ Swelling ______
❍ Pain Behind Eyes	❍ Sinus Trouble	❍ Vomiting	______	❍ Cuts ______
❍ Fainting	❍ Nervousness	❍ Diarrhea	______	❍ Bleeding ______
❍ Palpitation	❍ Chest Pain	❍ Constipation	❍ Anemia	❍ Broken Bones ______
❍ Neck Pain	❍ Shortness of Breath	❍ Cold Hands	❍ Heart Disease	❍ Bruising ______

Do you have, or have you ever had, any diseases or medical problems not listed? ❍ Yes ❍ No If so, please list: ______

______

Any additional information you would like the doctor to know about before beginning care at WellnessPlus: ______

______

Emergency Contact

Name: ______ Relation: ______

Home Phone: ( ) ______ Work Phone: ( ) ______

Address: ______

City / State / Zip: ______

Insurance Information

Insurance Company: ______ Phone # ______

Address: ______

City / State / Zip: ______

Insured's Name: ______ Insured's SS# ______ Group # ______

Insured's Birth Date: ______ Insured's Employer: ______

Personal Information

Address: ______

City / State / Zip: ______

Home Phone: ______ Work Phone: ______

Mobile Phone: ______ Pager: ______ Email: ______

Social Security #: ______ Birth Date: ______ Age: ______ Sex: ❍ M ❍ F

Drivers License #: ______

Marital Status: ❍ S ❍ M ❍ D ❍ W Spouse's Name: ______ # of Children: ______

Occupation: ______ Employer's Name: ______

Work Address: ______

City / State / Zip: ______

How were you referred to WellnessPlus? ______

Do you have an Attorney? ❍ Yes ❍ No Name: ______

Phone #: ______ Address: ______

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at WellnessPlus to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of WellnessPlus responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkable safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft-tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is preformed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by Physical Therapy modalities may cause minor burns to the skin. These are rare, but if it occurs, you should report it to your doctor, or a staff member at WellnessPlus

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature: ______________________ Date

Parent/Legal Guardian Signature: ______________________ Date

Seasonal Address Information

If you reside at a second address during part of the year, please provide the information below:

Second Address: ______________________

City / State / Zip: ______________________

Phone: ______________________

Check months at this address:

○ Jan ○ Feb ○ Mar ○ Apr ○ May ○ Jun ○ Jul ○ Aug ○ Sep ○ Oct ○ Nov ○ Dec