Wisconsin Wellness Clinic
Healing the mind. body, and spirit

Patient Information and Case History

Circle One **Chiropractic** **Stretch Therapy** **Massage** **Rehab**

(For Massage fill out Section A and B only and sign accordingly on the last page)

"*The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease.*" -- ***Thomas Edison***

A. PATIENT INFORMATION:

(Please Print)

Name:_____ Date: _____

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

Sex: Female Male Birthdate: _____ E-mail address:_____

Home Phone: _____ Cell Phone: _____ Cell Phone Carrier:_____

Work Phone: _____

Do you prefer to receive calls at: Home Cell Work No Preference

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ____years

Occupation:_____ Employer/School:_____

Spouse/Parent's Name:_____ Employer:_____ Work Phone _____

Emergency Contact:_____ Phone:_____ Relationship:_____

Method of payment for your first visit: Cash Check Credit Card

How did you hear about our office (please circle one)?

Insurance Provider Directory Internet Other Health Care Provider (Name _____)

Billboard Yellow Pages Newspaper Massage Therapist (Name _____)

Friend/Family Member (Name _____) Other _____

B. HISTORY OF PRESENT ILLNESS:

Main Reason for today's visit _____ When did you first notice the symptom(s)?_____

Where specifically is the problem (e.g. left side, right side, etc)? _____

Is this condition getting (circle one): Better Worse Staying the same

Type of Pain: Ache Sharp Dull Throb Numbness Shooting Burning Tight Other

Rate the severity of your pain (1=Mild, 10=Severe): 1 2 3 4 5 6 7 8 9 10

How frequently is your symptom present? Constantly Frequently Occasionally Intermittently

What treatment have you already received for your condition?

☐ Medication ☐ Physical Therapy ☐ Surgery ☐ Other: _____

Name of providers who have treated you for this condition and approximate date they were seen: _____

_____

Is the above complaint directly related to: Auto Accident – Yes No Work Injury – Yes No

If "YES", what date did this accident occur? _____

Are you filing this as a claim with an insurance carrier other than your own? Yes No

Check off any of the following conditions that you have experienced within the last 18 months:

Nervous
Depression
Multiple sclerosis
Post polio syndrome
Headaches
Stroke
Seizure disorders
Reduced sensation
Sleep disorders
Chemical dependency
Other:
Explanation:

Respiratory
Asthma
Emphysema
Sinusitis
Tuberculosis

Reproductive
Breast cancer
Endometriosis
Ovarian cysts
Prostate cancer
Painful menstruation
Are you pregnant?

Skin
Boils
Fungal infections
Herpes simplex
Warts
Eczema
Psoriasis
Skin cancer
Food Allergies

Circulatory
Anemia
Thrombophlebitis
Deep vein thrombosis
High blood pressure
Heart disease
Varicose veins
Clotting disorders

Digestive
GERD (reflux)
Ulcers
Crohn disease
Ulcerative colitis
Irritable bowel syndrome
Gallstones
Cirrhosis
Hepatitis

Musculoskeletal
Fibromyalgia
Rheumatoid arthritis
Osteoarthritis
TMJ dysfunction
Strains, sprains or tendinitis
Carpal tunnel syndrome
Thoracic outlet syndrome

Lymph/Immune
Edema
Leukemia/lymphoma
HIV/AIDS
Chronic fatigue syndrome
Lupus
Other autoimmune disorders

Endocrine
Diabetes
Hypothyroidism
Hyperthyroidism

Urinary
Kidney stones
Renal failure

C. PAST MEDICAL HISTORY

Have you ever had chiropractic care in the past? □ Yes □No

If YES, whom did you see and approximate date you last saw them? _____

Please check only those conditions are applicable. If none are applicable to you, check NONE OF THE ABOVE.

___Broken or Fractured Bones	___Osteoarthritis	___Eating Disorder	___Coughing Blood
___Circulatory Problems	___Ulcers	___Alcoholism	___A Congenital Disease
___Rheumatoid Arthritis	___Pace Maker	___Drug Addiction	___Depression
___Seizures/Convulsions	___Epilepsy	___AIDS/HIV	___Stroke
___Cancer	___Gall Bladder	___Excessive Bleeding	___High/Low Blood Pressure
___Ruptures	___Aneurysm	__Other _____	

NONE OF THE ABOVE

Have you had any major illnesses, injuries, falls, accidents or surgeries (please list approximate dates)? _____

_____

_____

Have you been treated for any health condition by a physician in the last year? □ Yes □ No

If yes, describe: _____

What medications or drugs are you taking? _____

_____

What vitamins are you taking? _____

_____

Do you have any allergies to any medications? □ Yes □ No

If yes, describe: _____

Do you have any allergies of any kind? □ Yes □ No

If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be:_____

_____

D. SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____

Do you use any tobacco products?_____ Do you smoke?____ If so, packs per day: _____

Do you consume caffeine?____ If so, how much per day: _____

Do you exercise?_____ If yes, what is the frequency and type of exercise?_____

What are your hobbies? _____

E. **FAMILY HISTORY**:

PARENTS:

Father: living ____ deceased ____ Current age if still living: _____ Cause of death and age at death if deceased: _____

Mother: living ___ deceased ____ Current age if still living: _____ Cause of death and age at death if deceased: _____

Do you have any family members who suffer from the same condition you do? If YES, please list their relation to you and their age: _____

FAMILY DISEASES: Check, if applicable, and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother.

→ Check if the following statement is applicable to you:

____ *As an adopted child, little is known of my birth parents or family.*

____ Tuberculosis	____ Cancer	____ Mental Illness
____ Diabetes	____ Asthma	____ Heart Disease
____ Stroke	____ Kidney Disease	____ Lung Disease
____ Arthritis	____ Liver Disease	____ Other _____

AUT

HORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or Wisconsin Wellness Clinic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of my care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office and Wisconsin Wellness Clinic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

CANCELLATION POLICY:

A credit card will be required to guarantee your appointment and reserve that time for you. Your card will not be charged, however you may use it to pay for services at the completion of your appointment. at the studio, home visits require a cash payment. The total amount of the services scheduled will be charged in full for clients who "no-show" or fail to cancel their reservation within a 24-hour time period. Multiple services (of two or more), and packages require 48 hours cancellation notice. If you need to make a change to the reservation on the day of the service, such as moving the appointment time, a fee may be applied due to limited availability.
If you are booking your massage within 24 hours of the actual appointment, there is no cancellation and you will be charged the full amount of the appointment.

LATE ARRIVAL POLICY:

As a courtesy to our other guests and staff, appointments will be automatically cancelled 15 minutes after scheduled start time and charged according to cancellation policy. We regret that late arrivals will not receive extension of scheduled appointments. In special cases, and when our schedule will allow, we may be able to accommodate a partial or full appointment. This will be at our discretion and only with proper, advanced notification of your late arrival.

SEXUAL MISCONDUCT:

Sexual misconduct is forbidden. Client understands that any illicit or sexually aggressive remarks, advances or gestures will result in the immediate termination of the session and client will be liable for full payment of the scheduled appointment.

Signature of Patient, Parent, Guardian, or Personal Representative	Date
Please print name of Patient, Parent, Guardian, or Personal Representative	Relationship to Patient

MASSAGE ONLY ACKNOWLEDGEMENTS:

Please initial the following Statements:

1. I am aware that draping will be used during the massage session._____
2. I understand that it is not within the scope of the massage session for the therapist to engage in breast massage of female clients._____
3. I understand that my feedback is an essential element in my treatment, therefore if at any time I should become uncomfortable during the massage, I may bring it to my therapist's attention and request that the session end._____
4. If I am unable to keep an appointment, I understand that an 12hr. notice is required, otherwise, I will be charged for the time reserved._____

5. I understand that any suggestive remarks and sexual references call for an immediate end to the session and I will be required to pay for the full session._____

Please Read the Following Statements, Sign At the Bottom of the Page

I have read and I fully understand this form in its entirety. If at any time there are changes in the information given or in my condition, I will notify my therapist, and update this form before receiving additional massages.

The Massage Treatment given here is for the sole purpose of stress reduction, relief from muscle tension of spasm and to increase circulation and energy flow.

The Massage Therapist does not diagnose of prescribe for medical illness,disease, or any other physical or mental disorder.

The Massage Therapist does not do spinal manipulations. Massage Therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physicianbe seen for any ailment that you have.

It is the Client's (your) responsibility to explain and discuss all physical conditions with the Massage Therapist so that they may do their job. Your Massage Therapist is an independent professional and is solely responsible for your treatment.

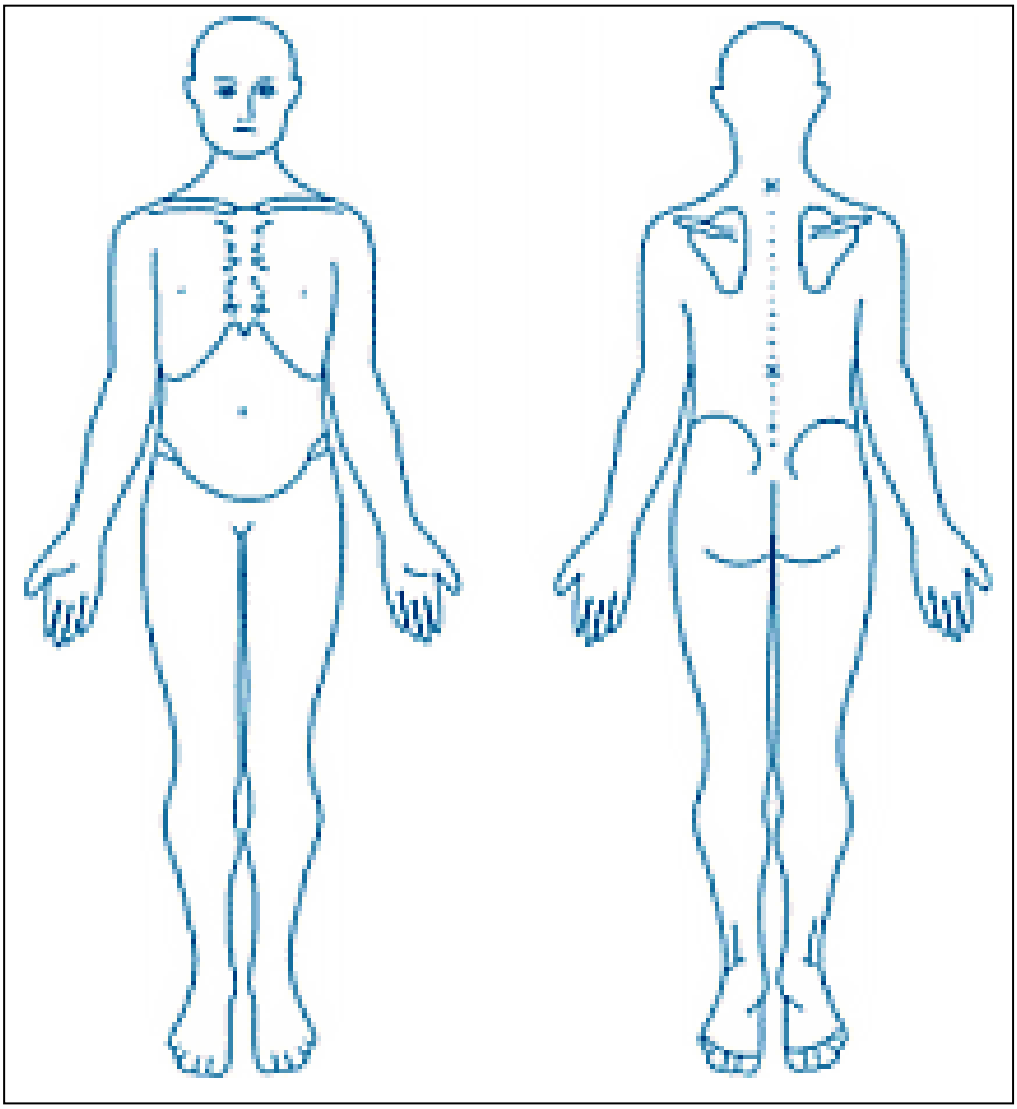
Signature:_____ Date:_____

****Therapist Section*****

Treatment Goals

Why are you here? What do you hope to accomplish?

Please indicate by **circling** where you have **pain**: Please place an **X** on areas to be **avoided**



Severity: How bad is the pain (use scale of 1-10)?
At Present At worst (last 24hrs)
Frequency: (#pain complaints/day)
Onset: Chronic Acute Sudden Gradual Trauma Related

Describe what you do that causes pain and what activities make it worse:

What would you like to be different?