THE WELLNESS WAY

The Wellness Way - Granville
1495 Granville Rd. Newark, OH 43055
thewellnessway.com
Online Store Referral Code: 1503

Patient Information

Date _____ Date of Birth _____

Legal Name: First _____ Middle _____ Last _____

Preferred Name: First _____ Middle _____ Last _____

Gender at birth ○ F ○ M Height _____ Weight _____

Married ○ Yes ○ No Spouse Name _____ # of Children _____

Home # _____ Cell # _____ Work # _____

Address _____

City _____ State _____ Zip _____

Patient Email _____

Emergency Contact _____ Emergency Relation _____ Emergency # _____

How Did You Hear About Us?

○ Current TWW Patient Patient Name _____

○ Social Media Which Platform _____

○ Other _____

Employment Information

Employed ○ Yes ○ No Employer Name _____

Employer Address _____

Employer City _____ Employer State _____ Employer Zip _____

Occupation _____ Work Supervisor _____ Supervisor # _____

Work Duties _____

Reason for this visit:

Describe the reason for this visit

When did this concern begin? _____ Has this concern ☐ Gotten Worse ☐ Stayed Constant ☐ Comes and Goes

Does this concern interfere with? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain _____

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Reason for this visit (continued)

Has this concern occurred before? ○Yes ○No Briefly Explain _____

Have you seen other doctors for this concern? ○Yes ○No

Type of treatment _____

Did an Injury Occur? If yes, complete the following

☐Work ☐Automobile ☐Home ☐Other Injury Date _____

Injury Origin _____

Describe Discomfort _____

Information Regarding Your Concern

Interfere w/ Activities ○Yes ○No Affected Sleep ○Yes ○No Frequency _____

Missed Work ○Yes ○No Unable to work from _____ Unable to work until _____

Affected Appetite ○Yes ○No Explain _____

Reduced Work ○Yes ○No Explain _____

Does it Worsen ○Yes ○No Explain _____

Weather Affects it ○Yes ○No Explain _____

What Aggravates Condition _____

What Improves Condition _____

Received Treatment ○Yes ○No Explain _____

X-rays Taken ○Yes ○No Explain _____

Pain Level Rating (Scale 1-10, 10 being worst) At its best _____ At its worst _____ Current Level _____

Current Medications (Prescribed or over-the-counter) _____

_____

_____

Current Supplements _____

_____

For cycling females only

Age of first period _____

Are you pregnant? ○Yes ○No Are you nursing? ○Yes ○No

Are you taking birth control? ○Yes ○No If yes, which one? _____

Do you have regular cycles? ○Yes ○No Menses frequency _____ Length of cycle _____

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For cycling females only (continued)

Do you have missed periods? Yes No Do you experience painful periods? Yes No

Do you have clotting? Yes No Are you menopausal? Yes No

Do you have breast implants? Yes No

How many pregnancies have you had? _____ Have you had any miscarriages? Yes No If yes, How many?_____

How many living children do you have? _____

Social Activity Information

Alcohol	Daily Weekly Occasionally Never	**Caffeine**	Daily Weekly Occasionally Never
Diet Food Products	Daily Weekly Occasionally Never	**Drugs**	Daily Weekly Occasionally Never
OTC Stimulants	Daily Weekly Occasionally Never	**Exercise**	Daily Weekly Occasionally Never
Homemade Food	Daily Weekly Occasionally Never	**Processed Food**	Daily Weekly Occasionally Never
Soft Drinks	Daily Weekly Occasionally Never	**Tobacco**	Daily Weekly Occasionally Never
Water	Daily Weekly Occasionally Never		

Patient Health History

Previous Chiropractic Care Yes No Date of Last Adjustment _____

Reason _____

Last Physical Exam _____ Primary Physician _____ Physician Phone _____

Physician City _____ Physician State _____ Physician Zip _____

Health Conditions _____

Broken Bones Yes No Treatment Yes No Explain _____

Sprains/Strains Yes No Treatment Yes No Explain _____

Hospitalized Yes No Explain _____

Surgery Yes No Explain _____

Auto Accident Yes No Explain _____

Struck Unconscious Yes No Explain _____

Eating Disorder Yes No Explain _____

Stroke Yes No Explain _____

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Patient Health History (continued)

- [ ] ADHD
- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Disease:

_____

- [ ] Back Pain
- [ ] Bed Wetting
- [ ] Bleeding Disorders
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Bypass Surgery
- [ ] Cancer
- [ ] Cataracts
- [ ] Chest Pain
- [ ] Chicken Pox
- [ ] Chronic Colds
- [ ] Cold Extremities
- [ ] Colic
- [ ] Congestive Heart Failure
- [ ] Constipation
- [ ] COPD/Emphysema
- [ ] Coronary Artery Disease
- [ ] Cramps
- [ ] CVA (Stroke/Transient Ischemic Attack)
- [ ] Dementia/Alzheimer's
- [ ] Depression
- [ ] Diabetes
  - ○ Type I ○ Type II ○ Juvenile
- [ ] Diagnosed Emotional/Mental
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Ear Infections
- [ ] Epilepsy
- [ ] Excessive Menstruation
- [ ] Eye Pain or Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Gallbladder Disease/Stones
- [ ] Glaucoma
- [ ] Gout
- [ ] Growing Pains
- [ ] Headache
- [ ] Hemorrhoids
- [ ] Hormone Replacement
- [ ] Hot Flashes
- [ ] Hypertension
- [ ] Irregular Heart Beat
- [ ] Irregular Menstrual Cycle
- [ ] Irritable Bowel Syndrome (IBS)
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Liver Disease/Cirrhosis
- [ ] Loss of Balance
- [ ] Loss of Memory
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Lung Disease
- [ ] Macular Degeneration
- [ ] Measles (Rubeola)
- [ ] Migraines
- [ ] Myocardial Infarction (Heart Attack)
- [ ] Nosebleeds
- [ ] Pacemaker
- [ ] Parkinson's
- [ ] Polio
- [ ] Poor Posture
- [ ] Prostate Trouble
- [ ] Reflux
- [ ] Recurring Fevers
- [ ] Retinal Disease
- [ ] Rubella
- [ ] Sciatica
- [ ] Scoliosis
- [ ] Seizures
- [ ] Shortness of Breath
- [ ] Sinus Infection
- [ ] Skin Sensitivity
- [ ] Sleep Problems/Insomnia
- [ ] Smoker
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of Ankles
- [ ] Swollen Joints
- [ ] Temper Tantrums
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Whooping Cough
- [ ] Other: _____

_____

_____

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Patient Birth History

Did patient's mother...

Have birth intervention? ○ Forceps ○ Vacuum Extraction ○ Caesarian Section

Have an emergency or planned delivery? ○ Yes ○ No

Have ultrasounds during pregnancy? ◉ Yes ○ No If yes, how many? _____

Have medications during pregnancy/delivery? ○ Yes ◉ No If yes, please list _____

Use cigarettes or alcohol during pregnancy? ○ Yes ○ No If yes, how much and how often? _____

Family Health History

Mother	○ Living	○ Deceased	Cause of Death _____
Maternal Grandmother	○ Living	○ Deceased	Cause of Death _____
Maternal Grandfather	○ Living	○ Deceased	Cause of Death _____
Father	○ Living	○ Deceased	Cause of Death _____
Paternal Grandmother	○ Living	○ Deceased	Cause of Death _____
Paternal Grandfather	○ Living	○ Deceased	Cause of Death _____

Insurance Information

Please provide a copy of your driver's license and insurance card(s).

Terms of Acceptance

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 Clinics. I authorize The Wellness Way and it's staff to examine and deliver care as they see fit. I thereby authorize The Wellness Way 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 48 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 signing below, I agree to the financial policy described above and will adhere to all of it's practices.

Signature _____ Date _____