## Personal Information

Date: ___/___/_____ First Name: _____ Last Name: _____ Initial: _____

How would you like us to address you? _____ (nickname, title, etc.)

How were you referred to our office? _____

Address: _____City:_____State:_____ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____ Cell: ( )_____

Email: _____ (we will not send you jokes or junk)

Date of Birth:___/___/____ SS# _____ Spouse's Name _____

Employer: _____ Occupation _____

Address_____City_____St_____Zip_____

Drivers Lic # _____ state_____

## Primary Insurance

Insurance Company: _____ Phone #_____

Insured's Name _____ Insured's DOB_____

Insured's SS#_____ Relationship _____

Policy/ID#_____ Group #_____

Insured's Employer _____ Occupation _____

Employer's Address _____

## Secondary Insurance

Insurance Company: _____ Phone #_____

Insured's Name _____ Insured's DOB_____

Insured's SS#_____ Relationship _____

Policy/ID#_____ Group #_____

Insured's Employer _____ Occupation _____

Employer's Address _____

**First Name: _____ Last Name: _____ Date of Birth: ____/____/_____**

**Primary Care Physician:** Name: _____ Phone: _____

Address: _____

Please fill out the following section if accident related:

**Auto Information:** Company: _____ Phone: _____ Date of Accident: ___/___/___

Adjuster's Name: _____ Policy: _____ Claim#:_____

**Attorney Information** (If Personal Injury Case):

Atty Name _____ Phone Number: _____

Address _____

**Worker's Comp Information**

Date of Accident _____ Supervisor's Name _____

Date the accident was reported _____

To whom was the accident reported _____

Worker's Comp Insurance Carrier _____

Phone # (  ) _____ Adjuster's Name _____ Claim #: _____

**CONSENT TO TREAT:** I hereby authorize Well Being Chiropractic Center / Dr. Joseph Yonce / Dr. Gina Barros and their assistants to perform examinations, physical therapy, and / or noninvasive diagnostic testing (including X-rays), and any other treatment that is medically necessary to me today and throughout the course of my treatment plan.

Signature: _____ Date: _____

**CONSENT TO TREAT A MINOR CHILD:** I, _____, hereby give my permission for Well Being Chiropractic Center to treat my minor child with examinations, physical therapy and any other noninvasive procedures that are medically necessary.
Parent /Guardian: _____ Signature: _____ Date: _____

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES:** By signing on the line below, I am indicating that I have been given a copy of the Health Insurance Accountability and Portability Act to read. I was also informed by Well Being Chiropractic that a copy of these privacy practices can be made available to me anytime.

Patient Signature: _____ Date: ____/____/_____ Witness: _____

**To our valued patient's**: In order to keep the cost of your healthcare at a moderate price, Well Being Chiropractic is a zero balance facility. This means we do not bill our patient's or send monthly statements. Co-pay or Coinsurance is due on each visit.
**Scheduling Appointments**: Well Being Chiropractic Center understands that sometimes circumstances prevent our patient's from keeping their scheduled appointments. If you cannot keep your regularly scheduled appointment please notify our office 24 hours in advance so that others in need can take your appointment slot. Also, if you are running more than 15 minutes late for your scheduled appointment, please notify our office. Thank you.

**First Name: _____ Last Name: _____ DOB: _____/_____/_____**

## Confidential Case History

O - Occasional
F - Frequent
C - Constant

Please use the frequency above and check off any of the following symptoms that you have experienced in the past year. If the symptom does not pertain to you, leave it blank.

| | O | F | C |
|---|---|---|---|
| Allergy | _ | _ | _ |
| Chills | _ | _ | _ |
| Convulsions | _ | _ | _ |
| Dizziness | _ | _ | _ |
| Fainting | _ | _ | _ |
| Fatigue | _ | _ | _ |
| Fever | _ | _ | _ |
| Headache | _ | _ | _ |
| Loss of Sleep | _ | _ | _ |
| Weight Loss | _ | _ | _ |
| Nervous | _ | _ | _ |
| Depressed | _ | _ | _ |
| Neuralgia | _ | _ | _ |
| Numbness | _ | _ | _ |
| Sweats | _ | _ | _ |
| Tremors | _ | _ | _ |
| | **O** | **F** | **C** |
| Arthritis | _ | _ | _ |
| Bursitis | _ | _ | _ |
| Foot trouble | _ | _ | _ |
| Hernia | _ | _ | _ |
| Pain: | | | |
| Low Back | _ | _ | _ |
| Neck | _ | _ | _ |
| Shoulders | _ | _ | _ |
| Arms | _ | _ | _ |
| Elbows | _ | _ | _ |
| Hands | _ | _ | _ |
| Hips | _ | _ | _ |
| Legs | _ | _ | _ |
| Knees | _ | _ | _ |
| Feet | _ | _ | _ |
| Tailbone | _ | _ | _ |
| Poor Posture | _ | _ | _ |
| Sciatica | _ | _ | _ |
| Spinal Curve | _ | _ | _ |
| Swollen Joints | _ | _ | _ |

| | O | F | C |
|---|---|---|---|
| Belching/Gas | _ | _ | _ |
| Colitis | _ | _ | _ |
| Colon Trouble | _ | _ | _ |
| Constipation | _ | _ | _ |
| Diarrhea | _ | _ | _ |
| Digestion | _ | _ | _ |
| Abdomen | _ | _ | _ |
| Hunger | _ | _ | _ |
| Gall Bladder | _ | _ | _ |
| Hemorrhoids | _ | _ | _ |
| Intestine worm | _ | _ | _ |
| Jaundice | _ | _ | _ |
| Liver trouble | _ | _ | _ |
| Nausea | _ | _ | _ |
| Stomach pain | _ | _ | _ |
| poor appetite | _ | _ | _ |
| Vomitting | _ | _ | _ |
| Vomit blood | _ | _ | _ |
| | **O** | **F** | **C** |
| Asthma | _ | _ | _ |
| Colds | _ | _ | _ |
| crossed eyes | _ | _ | _ |
| Deafness | _ | _ | _ |
| Dental Decay | _ | _ | _ |
| Earache | _ | _ | _ |
| Ear Discharge | _ | _ | _ |
| Ear Noises | _ | _ | _ |
| Glands | _ | _ | _ |
| Thyroid | _ | _ | _ |
| Eye Pain | _ | _ | _ |
| Failing Vision | _ | _ | _ |
| Far sighted | _ | _ | _ |
| Gum trouble | _ | _ | _ |
| Hay fever | _ | _ | _ |
| Hoarseness | _ | _ | _ |
| nasal block | _ | _ | _ |
| Near sighted | yes | | no |
| Nose bleeds | _ | _ | _ |
| Sinus infection | _ | _ | _ |
| Sore throat | _ | _ | _ |
| Tonsillitis | _ | _ | _ |

| | O | F | C |
|---|---|---|---|
| Hard arteries | _ | _ | _ |
| high bld pres | _ | _ | _ |
| low bld pres | _ | _ | _ |
| heart pain | _ | _ | _ |
| bad circulation | _ | _ | _ |
| fast heartbeat | _ | _ | _ |
| slow heartbeat | _ | _ | _ |
| swollen ankles | _ | _ | _ |
| | **O** | **F** | **C** |
| Chest Pain | _ | _ | _ |
| chronic cough | _ | _ | _ |
| diff. breathing | _ | _ | _ |
| spit up blood | _ | _ | _ |
| spit up phlegm | _ | _ | _ |
| wheezing | _ | _ | _ |
| | **O** | **F** | **C** |
| boils | _ | _ | _ |
| bruise easily | _ | _ | _ |
| dryness | _ | _ | _ |
| hives/allergy | _ | _ | _ |
| itching | _ | _ | _ |
| skin rash | _ | _ | _ |
| varicose veins | _ | _ | _ |
| | **O** | **F** | **C** |
| bed wetting | _ | _ | _ |
| blood in urine | _ | _ | _ |
| freq. urination | _ | _ | _ |
| kidney infect. | _ | _ | _ |
| kidney stones | _ | _ | _ |
| urination pain | _ | _ | _ |
| prostate prob. | _ | _ | _ |
| For women: | **O** | **F** | **C** |
| Breast pain | _ | _ | _ |
| cramps | _ | _ | _ |
| heavy flow | _ | _ | _ |
| hot flashes | _ | _ | _ |
| irregular cycle | _ | _ | _ |
| menopausal | _ | _ | _ |
| discharge | _ | _ | _ |

Pregnant yes___ No___

**First Name: _____ Last Name: _____ DOB: ____/____/_____**

**Please circle the follow conditions you have or have had:**

| | | | | | |
|---|---|---|---|---|---|
| Cancer | Cold sores | Goiter | Measles | Rheumatic fever | Epilepsy |
| Anemia | Diabetes | Gout | Miscarriage | Scarlet fever | Venereal disease |
| Appendicitis | pneumonia | heart disease | mult.sclerosis | stroke | Whooping cough |
| exzema | HIV/AIDS | mumps | tuberculosis | arthritis | Polio |
| emphysema | influenza | pleurisy | ulcers | fever blisters | arteriosclerosis |

**Tell us about why you are here today:**

What is your **major** complaint? _____

When did it start?_____ How did it start? gradually___ suddenly___

Explain: _____

Have you ever had this same or a similar condition in the past? yes____ no____

What aggravates your condition? (ex: bending, lifting, etc.)_____

What brings relief? (ex: rest, ice, etc.)_____

How does it feel? (cicle) sharp achy dull deep stabbing stinging burning numb tingling crawling

Does it radiate to any other part of your body? yes___ no___ If yes, where? _____

With 0 representing no pain at all and 10 representing severe pain, please rate your pain: _____

When is the pain at its worse? (upon waking, with movement, etc.)_____

What past injuries may have caused this condition? (ex: accident, falls, sports injuries, etc.)

_____

What (if any) other doctors have you seen for this condition? _____

Briefly describe your occupational duties: _____

Have you ever fractured a bone? yes___ no___ If yes, which one and when? _____

List any past surgeries: _____

Family Health History (parents, siblings) if relevant: _____

Please list any medications you are presently taking (be sure to include over the counter medications and vitamins). _____

_____

for additional symptoms/complaints please use a separate page