Wise Chiropractic
Family Wellness Center

5875 S. Rainbow Blvd, Suite 201
Las Vegas, NV 89118
(702) 248-6292

GENERAL INFORMATION

Full Name ____ Age __________ DOB ____/____/____
Home Phone (__) ______________Cell (__) ________________E-mail_______________________
Home Address ______________________________ City ____________ State ___ Zip __________
Marital Status S M D W Name of Spouse ____
Occupation _________________________ Business Phone ______________________________
Whom may we thank for referring you to our office ______________________________________
Names and ages of children ____
____
Have your children received previous Chiropractic care? Yes No
Have you ever received Chiropractic care? Yes No With whom? ____________________________
How often did you go?________________________________ Date of last visit: ____/_____/______
Reason for ending care ____
Have you had spinal x-rays? Yes No What did they show?____________________________________
Have you ever received Chiropractic Wellness care? Yes No
What hobbies or activities do you enjoy?____
Name of current medical doctor: _________________________Phone # (__) __________________
Date of last medical consultation ______/______/______ Reason _____________________________

Do you consult your M.D. on a regular basis? Yes No If so, why? ____________________________

For women: Are you pregnant? Yes No

ABOUT YOUR HEALTH HISTORY

Throughout life, stress and traumatic events can damage your spine and nerve system. This stress may be PHYSICAL, CHEMICAL and/or EMOTIONAL. The information below will help us better understand the stress that you have experienced. We analyze this information along with your examination findings.

HISTORY OF PHYSICAL STRESS (Birth to Present)

Research indicates that the birth process causes trauma to a baby's delicate spine and nerve system. Please circle (to the best of your recollection). Was your birth:

Drug induced C section Breech Natural Home Birth Midwife Vacuum extraction Prolonged Umbilical cord around neck Forceps Hospital

GENERAL PHYSICAL TRAUMA:

Most traumas occur in the early years (between birth and early twenty's). During that time your spine and nerve system are growing and are more vulnerable to injury.

Have you had accidents related to the following: (Circle all that apply and give dates.)
Automobile Motorcycle Bicycle Sports Other: ____
If yes, please explain: ____
____

Have you ever injured your nerve system or spine? (Head, neck, back, pelvis, hips): Yes No If yes, please explain: ____
____

Have you broken any bones or sprained any part of your body? Yes No
If yes, please explain: ____
Have you ever had surgery or have you been hospitalized? Yes No
If yes, please explain: ____

HISTORY OF CHEMICAL STRESS

Chemical stress occurs during life due to toxic substances that are breathed, injected, taken orally, or placed on the skin and absorbed into the body. The following will give us insight into any exposures you may have had.

Have you ever been vaccinated? Yes No How many times? 0-5 6-10 11 or more

Do you currently take? Prescription drugs, Over the counter, Recreational

Please list.____

Have you previously been exposed to or are you currently exposed to?
Cortisone Flu shots Chemicals Fumes Dust Smoke Cigarettes

Do you consume? Alcohol Coffee Tobacco Diet Soda Fast Food Candy

HISTORY OF EMOTIONAL STRESS

Emotional stress creates tension in your spine and nerve system. Although it is common to be under stress, it can affect your overall health. Please circle the emotional stresses you have encountered.

Childhood trauma Yes No	**Relationships** Yes No	**Illness** Yes No
Loss of Loved One Yes No	**Family** Yes No	**School** Yes No
Divorce/Separation Yes No	**Financial** Yes No	**Abuse** Yes No
Lifestyle change Yes No	**Work** Yes No	**Other** Yes No

QUALITY OF LIFE

How do you grade your physical health?	Excellent	Good	Fair	Poor
How do you grade your emotional health?	Excellent	Good	Fair	Poor
How do you grade your nutritional health?	Excellent	Good	Fair	Poor
How do you rate your overall "quality of life"?	Excellent	Good	Fair	Poor

REASON FOR SEEKING CHIROPRACTIC CARE

What is the main reason for your visit to our office today?
____
____

Please circle the symptoms you either have now or have had within the past year.

Back pain	Numbness	Fatigue	Hair loss
Neck pain	Cold hands/feet	Ears ring	Depression
Leg/knee/foot pain	Asthma	Chest pain	Nail fungus
Shoulder pain	Allergies	Food cravings	Catch colds easy
Elbow/wrist pain	Indigestion	Skin problems	Constipation
Headaches	Hot flashes	Earaches	Diarrhea
Dizziness	Hormone problems	Sinus problems	Arthritis
Insomnia	High blood pressure	Feeling old	Other____________

Is your current health affecting any of the activities below? (Please circle)

Work: Yes No	**Recreation:** Yes No	**Sleep** Yes No
Social life: Yes No	**Walking:** Yes No	**Sitting:** Yes No
Exercise: Yes No	**Eating:** Yes No	**Family:** Yes No
School: Yes No	**Marriage:** Yes No	**Finances:** Yes No

If your current health condition was allowed to continue for the next 5 years, how do you think it would affect you? ____

PLEASE CHECK YOUR CURRENT HEALTH GOALS

I am only concerned with my immediate problem and want a temporary quick fix.
I am concerned with my immediate problem and preventing its return.
I want to achieve optimum health and well-being on every level!
I am interested in wellness care for myself and/or my family.

Terms of Acceptance

Wise Chiropractic is a Family Wellness Center specializing in the detection, correction and prevention of vertebral subluxations (spine and nerve system problems). We do not treat or diagnose medical conditions nor dispense drugs. Today you will have a consultation and examination to evaluate the health of your spine and nerve system. The information will be analyzed. You will then be scheduled for a special visit with the doctor to discuss the results of your exam. If we accept your case, you will receive written recommendations outlining the steps needed to improve your health. Our methods include spinal adjustments, nutrition, rehabilitative exercises, orthotics, and stress reduction. If accepted as a patient, I give consent to any and all treatment rendered to Myself or my Children.

By signing below, I understand and agree to these terms

Signature ______________________________________ Date ______/______/______

Signature of Parent (for minor): _______________________ Date ______ /______/______

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, “I” and “my” refer to the patient,

and “Chiropractor” refers to Dr. Jonathan Wise .

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been given the opportunity to read a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Freshetarian Health Recovery System. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name: ____

Signature: ____

Date: _______________