

HISTORY QUESTIONNAIRE

Please state primary reason for contacting our office: _____

mild moderate severe ~ Please rate your pain on a scale of 0-10 (0 being no pain) ___/10

constant intermittent

symptoms ↑ with activity symptoms ↓ with activity

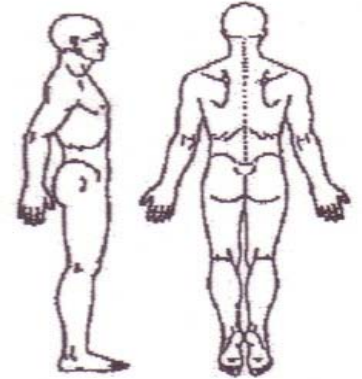
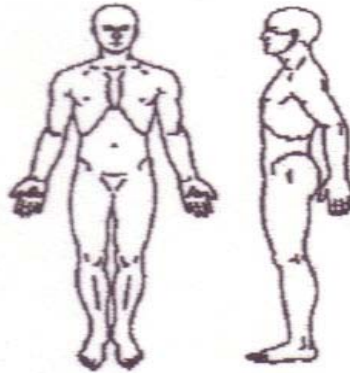
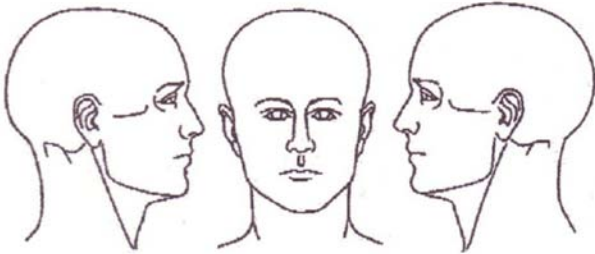
getting worse getting better no change

Date of Injury: _____

If no injury, when did the problem begin? _____

Have you been given a diagnosis for any of these conditions? If so, what? _____

And by whom? _____



To what extent does the condition(s) interfere with your daily activity (work, exercise, sleep, sex etc.)? _____

What kind of treatments have you tried? _____

Please indicate any areas causing discomfort or distress: _____

Please list any other areas of discomfort or concern: _____

What are your goals/expectations for seeking care? _____

Past Medical History:

Please note dates of each:

- | | | | | |
|--|--------------------------------------|--|---------------------------------------|------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Lupus | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Other _____ | | | |

Surgeries (types & dates): _____

Significant Traumas: _____

Allergies (environmental, chemical, food): _____

Occupational Stress (chemical, physical, psychological) Yes No

Family Medical History:

- | | | | |
|--|--|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ | |

Medications:

What medications and/or supplements are you currently taking? _____

For what reason: _____

Have you had any courses of antibiotics recently? Many A few 1 or 2 None

Habits:

Do you have a regular exercise program? Please describe: _____

Are there any areas of your life that you find stressful? Please describe: _____

Usage of:

Cigarettes _____ per _____ Alcohol _____ per _____ Drugs _____ per _____
Tea _____ per _____ Soft Drinks _____ per _____ Coffee _____ per _____

Do you follow any type of special diet (e.g., vegetarian, vegan, medical related, other)? If yes, what type? _____

Musculoskeletal tension, dysfunction and/or pain can be signs of nervous system imbalances. Please check all symptoms that you experience, current (C) or Past (P):

General

- Recurrent Infections
- Night Sweats
- Sweat easily
- Fevers
- Chills
- Bleed or bruise easily
- Strong thirst (prefer hot or cold?)
- Overweight
- Thirst with no desire to drink?
- Fatigue
- Sudden energy drops
Time of day _____
- Poor Sleep
- Tremors
- Edema
- Underweight
- Change in appetite

Skin

- Rashes
- Hives
- Itching
- Eczema
- Oozing
- Pimples
- Dry skin/scalp
- Loss of hair
- Recent moles
- Changes in hair/skin
- Hairpiece
- Reactions to skin care products
- Latex allergy

Head/Eyes/Ears/Nose/Throat

- Sore eyes
- Facial Pain
- Nasal discharge
- Headaches
- Discharge from ear
- Blocked Nose
- Sores on lips/mouth
- Nose bleeds
- Grinding teeth
- Migraines
- Dizziness
- Poor hearing/hearing aid
- Swollen glands
- Tonsillitis
- Ringing in ears
- Blurry vision
- Poor night vision
- Spots in front of eyes
- Eye pain
- Squint
- Glasses/Contact lenses
- Jaw/Teeth pain
- Cataracts

Cardiovascular

- Pacemaker
- High Blood Pressure
- Low Blood Pressure
- Chest discomfort/pain
- Heart palpitations
- Cold hands or feet
- Swelling of hands or feet
- Blood clots
- Spider veins
- Varicose veins
- Fainting

Genital-urinary

- Pain on urination
- Urgency with urination
- Frequent urination
- Blood in urine
- Decrease in urinary output
- Unable to hold urine
- Incontinence at night
- Wake to urinate at night
- Dribbling urination
- Kidney stones
- Prostate problems
- Impotency
- Changes in sexual drive
- Rashes

Musculoskeletal

- Neck ache/pain
- Back ache/pain
- Hip ache/pain
- Sciatica
- Knee ache/pain
- Shoulder pain
- Elbow/Forearm pain
- Hand/Wrist pain
- Foot/Ankle pain
- Joint/Bone problems

Respiratory

- Difficulty breathing
- Pain with breathing
- Shortness of breath
- Bronchitis
- Pneumonia
- Asthma/Wheezing
- Recurrent cough
- Phlegm production, what color?

Digestion

- Bad breath
- Bleeding gums
- Change in appetite
- Nausea
- Vomiting
- Heartburn
- Indigestion
- Belching
- IBS/Crohn's disease
- Abdominal pain or cramps
- Abdominal bloating
- Weight gain
- Weight loss
- Loose Stools/Diarrhea
- Strong smelling stools
- Bloody stools
- Black stools
- Constipation
- Pain with passing stools
- Gas
- Rectal pain
- Hemorrhoids
- Anorexia nervosa
- Bulimia
- Chronic laxative use

Behavioral

- Vacant
- Moody
- Easily susceptible to stress
- Aggressive/Bad temper
- Lose control of emotions
- Anxiety
- Panic Attacks
- Depression
- Fear
- Substance abuse
- Other _____

Have you ever been treated for emotional problems?
 yes no

Have you ever considered or attempted suicide?
 yes no

Neurological

- Seizures
- Nerve damage
- Paralysis
- Stroke
- Sleep disorder
- Concussion
- Vertigo
- Lack of coordination
- Loss of balance
- Poor memory
- Difficulty in concentrating

Gynecological

- Age at first menses _____
- How many days does your menstrual flow last? _____
- How many days are there between the start of each period? _____
- Age of Menopause _____
- PMS
 - No Period
 - Irregular Periods
 - Irregular flow (heavy, scanty, etc.) _____
 - Painful Periods
 - Clots
 - Endometriosis
 - Infertility
 - Vaginal discharge
 - Uterine fibroids
 - Breast lumps

- Date of Last Pap _____
- # of Pregnancies _____
- # Births _____
- # Premature Births _____
- Forceps Delivery yes no
- Are pregnant now? yes no
- Due Date: _____
- Do you practice birth control? yes no
- If yes, what type? _____
- for how long? _____

Other: _____

Is there anything else you would like to add? _____

Thank you for taking the time to fill out this form thoroughly. It will help us serve you better.

Signature: _____ **Date:** _____



Informed Consent & Policies

I authorize the practitioners of The Wellness Solution to provide the named procedures below. I intend this consent form to cover the entire course of treatment for my presenting condition and for any future conditions for which I seek treatment.

Chiropractic: including but not limited to, spinal adjustments, mobilization, and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

Acupuncture: including but not limited to, insertion of needles, use of moxa heat treatments, Oriental massage, cupping, electrical stimulation, Chinese herbal medicine, and other styles of Oriental medicine that are relevant to your diagnosis.

Massage: including but not limited to, manual therapy to assist with relaxation, stress reduction, pain management, body awareness and integration of mind, body and spirit.

~Please understand that chiropractic appointments are booked every 20 minutes. If you are running late, kindly take a moment to call and we will do our best to accommodate you. If you are late for your appointment, your session will be shortened or rescheduled.

~Please understand that massage and acupuncture are booked hourly and your treatment will therefore will end five to ten minutes prior to the next scheduled appointment. If you are running late, kindly take a moment to call and we will do our best to accommodate you. If you are more than 15 minutes late, your session will either be shortened or rescheduled.

~Please be advised that when a practitioner of The Wellness Solution refers you for a complementary therapy, such as massage, acupuncture, or chiropractic care, you have the freedom to choose any therapist to perform said treatment. The purpose of our multidisciplinary center is to expand our patients' choice of quality practitioners, not to direct you to any particular therapist.

Cancellation policy: Please be on time for your appointment as our hours are limited and we are often booked in advance. There is no charge for cancellations received at least 24 hours in advance. If you must cancel with less than 24 hours notice or you do not show for an appointment, we reserve the right to charge the full amount for the scheduled appointment.

We reserve the right to refuse or discontinue service at any time, for any reason, in an effort to ensure the safety of our clients and ourselves. If possible we will provide a referral to another provider.

I hereby release The Wellness Solution from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation. I have reported to the best of my knowledge all health conditions that I am aware of and will inform my practitioner of any changes to my health. The practitioner will not be held responsible for any health conditions or diagnosis' which are pre-existing, given by another health care practitioner, or are not related to the conditions diagnosed and/or treated at this clinic.

I hereby authorize my practitioner(s) of The Wellness Solution permission to consult the patients' primary health care providers regarding my health and treatment. **Initial**_____

Please sign below after you have read and understand these policies.

_____ Printed patient name _____ Date

_____ Patient signature

Consent to Treatment of Minor Child:

I hereby authorize practitioners of The Wellness Solution to administer care as deemed necessary to my child.

_____ Child's name _____ Date

_____ Parent or legal guardian signature



The Wellness Solution
Notice of Privacy Practices Acknowledgement

We keep a record of the health care services that we provide you. You may ask to see and copy that record; you may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

*You may refuse to sign this acknowledgement

By my signature below, I acknowledge receipt of the Notice of Privacy Practices:

Patient or Personal Representative Signature:

Date:

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____

Relationship (parent, guardian, Power of Attorney, etc.) _____

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of Personal Representative

Date

Additional Disclosure Authority

In addition to the allowable disclosures described in the "Notice of Privacy Practices", I hereby specifically authorize disclosure of my protected healthcare information to the following person/people indicated below:

Appointment Information _____

Account Information _____

Healthcare Information _____

Any Member of my immediate family: Yes___ No___

Spouse Only: Yes___ No___

Other (please specify) _____ Yes___ No___

Signature: _____

Relationship to patient: _____

The Wellness Solution Disclosure

At The Wellness Solution, our practitioners work collaboratively to meet the individual needs of our patients/clients. We often coordinate your care and discuss your records, treatment and progress in order to be as effective as possible.

I hereby grant permission for the practitioners and instructors of The Wellness Solution to discuss my health records and treatment in order to maximize the effectiveness of my care.

Patient or Personal Representative

Date

Modified: 02/2009



- CHIROPRACTIC • ACUPUNCTURE • MASSAGE • NUTRITION • REIKI THERAPY
- AESTHETICS • BOOT CAMPS • PILATES • YOGA • ZUMBA

Office Policies

Visit Policy:

1. To ensure the best possible outcome, it is imperative to maintain your visit schedule according to the Doctor's recommendations.
2. If you are ever unable to keep a scheduled appointment, we require that you call as soon as possible to reschedule that visit. It is your obligation, as the patient, to make up a missed appointment within seven (7) days of the cancellation.
3. We sincerely attempt to honor all appointments at the scheduled time. If you are late, you may be asked to wait for the next available appointment.
4. **ALL NO SHOW OR CANCELLED APPOINTMENTS WITH LESS THAN 24 HOUR NOTICE, WILL BE CHARGED A MINIMUM OF \$30 FOR THAT MISSED APPOINTMENT.**
5. Cancellation and no show fees are subject to change. You will be held responsible for any rate increases without having to resign or initial this document. Any changes will be posted in our office for one month to notify our patients.

_____ **Initials**

Payment Policy:

1. All payments for treatment are required at the time of service.
2. It is the policy of this office that all charges for services rendered are ultimately the patients responsibly including those not reimbursed by third party payers.
3. Any balance over 90 days will be subject to additional fees and/or collections.
4. In the event that you choose to discontinue your care, any outstanding balance will be due immediately.
5. With pre-payment plans, please be aware that you are not under contract. Any fees that are paid in advance are completely transferable to family members or refundable for any unused portion. Please note that if a refund request is made, your charges will be pro-rated for the original fee of the services used and you will forfeit any complimentary visits included in your plan.

_____ **Initials**

I have read and understand the above office policies.

Patient Signature

Date



The Wellness Solution Services & Fee Schedule

CHIROPRACTIC

Private Consultation (new patients only).....	Free
New Patient Exam (approx. 45 min.)	\$75
Chiropractic Treatment (approx. 20 min.).....	\$55
Chiropractic Treatment with Graston Technique (if indicated).....	\$65

ACUPUNCTURE

Treatment (1 Hour).....	\$70
Acupuncture & Herbal Prescription Combined Initial Consultation	\$100
Postpartum Acupuncture Package	\$300
Herbal Consult: Initial Visit	\$40
Herbal Consult: Follow-up Visit	\$30

MASSAGE

Deep Tissue Therapeutic Massage (30/60/90 Min)	\$40/\$70/\$95
Prenatal Massage Therapy (60 Min).....	\$70

STRUCTURAL INTEGRATION

1 Hour Session	\$100
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REIKI

1 Hour Session	\$75
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NUTRITION COUNSELING

Initial Consultation (1 Hour).....	\$125
Follow Up Session (30 Minutes)	\$45
Comprehensive Package (Initial Consultation + 3 Follow Up Sessions)	\$225
Green & Clean Package (Initial Consultation + weekly E-mail Follow Up)	\$145
“New You” Two-Week Cleanse.....	\$79
Fit And Trim Plan (6-week Nutrition/Fitness Program)	\$599

HOLISTIC AESTHETICS

AHA Organic Glycolic Facial	\$80
The Rose-C Facial.....	\$80
The Blueberry Bliss Facial	\$80
The Vitamin C Paraffin Facial	\$90
The Clean Classic Facial.....	\$80
The Best Back Facial	\$70
Bright Eyes – Eye Treatment.....	\$40
Your Lips Will Have a Ball – Lip Treatment	\$30
The Stone Crop Purifier	\$80
Just for Teens Facial.....	\$70
Gentleman’s Hungarian Escape	\$80
The Enlightening Facial.....	\$90
Harvest Peel.....	\$100
Waxing**	

** Please visit our website at www.thewellnesssolution.net for a complete list of services with descriptions.