



a wellness partnership

# Your Facts



Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email: \_\_\_\_\_

How did you find us? Patient (who): \_\_\_\_\_ Doctor (who): \_\_\_\_\_ Staff (who): \_\_\_\_\_

(circle one) Promotion/Event Internet Newspaper Signage Business Insurance Other: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender (circle one): Male Female Marital Status (circle one): M D W S

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ Phone # (PCP): \_\_\_\_\_

Are you currently taking any medications or supplements? (Please include regularly used over the counter medications).....

| Medication Name | Dosage and Frequency |
|-----------------|----------------------|
|                 |                      |
|                 |                      |
|                 |                      |
|                 |                      |
|                 |                      |
|                 |                      |

| Supplement Name | Dosage and Frequency |
|-----------------|----------------------|
|                 |                      |
|                 |                      |
|                 |                      |
|                 |                      |
|                 |                      |
|                 |                      |

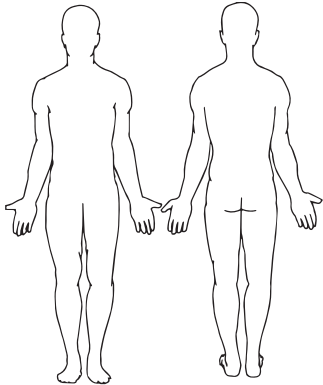
Do you have any medication, food, or environment allergies?

| Medication, Food or Location | Reaction |
|------------------------------|----------|
|                              |          |
|                              |          |
|                              |          |
|                              |          |
|                              |          |
|                              |          |

Please list 3 major health goals in order of priority:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

### Pain Location



Front

Back

### Present Condition

List conditions in order of concern and mark location of pain.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

(minor) **Pain Scale** (extreme)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

|   |   |   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|   |   |   |   |   |   |   |   |   |    |
|   |   |   |   |   |   |   |   |   |    |
|   |   |   |   |   |   |   |   |   |    |
|   |   |   |   |   |   |   |   |   |    |

Has condition changed since onset?  Yes  No  Better  Worse

Explain: \_\_\_\_\_

What makes pain better? \_\_\_\_\_

Worse? \_\_\_\_\_

Difficult activities: \_\_\_\_\_

### Who Have You Seen:

Who have you seen for your symptoms, and when? **Date**

Chiropractor: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

Physical Therapist: \_\_\_\_\_

Other: \_\_\_\_\_

### Have You Had:

Blood analysis.....  Yes  No \_\_\_\_\_ When

Blood pressure check.....  Yes  No \_\_\_\_\_ When

Bone density.....  Yes  No \_\_\_\_\_ When

Eye exam.....  Yes  No \_\_\_\_\_ When

Feelings of hopelessness.....  Yes  No \_\_\_\_\_ When

Feelings of depression.....  Yes  No \_\_\_\_\_ When

Feelings of anxiety.....  Yes  No \_\_\_\_\_ When

Feelings of panic.....  Yes  No \_\_\_\_\_ When

MRI.....  Yes  No \_\_\_\_\_ When

Spinal x-ray.....  Yes  No \_\_\_\_\_ When

### Current Symptoms

- 1**
- Knee Pain
  - Leg Cramps
  - Numbness in Toes
  - Tingling in Legs
  - Weakness In Legs
  - 
  - Urinating Issues
  - Lower Back Pain
- 2**
- Ringing in Ears
  - 
  - Bladder Infections
  - Belching
  - Constipation

- 3**
- Indigestion
  - Vomiting
  - 
  - Arm Pain
  - Circulatory Problems
  - Hands Cold
  - Mid-Back Pain
  - Numbness in Fingers
  - Shortness of Breath
- 4**
- Shoulder Pain
  - Tingling in Arms

- 5**
- Back Pain
  - Dizziness
  - Hair Loss
  - Hay fever
  - Hives
  - Loss of Balance/Dizzy
  - Neck Pain/Stiffness
  - Nervousness
  - 
  - Bruise Easily
  - Diarrhea
  - Feet Cold
  - Frequent Colds
  - Hemorrhoids
- 6**

- 6**
- Loss of Smell/Taste
  - Muscle Spasms
  - Sight Sensitivity
  - Sinus Problems
  - 
  - Cold/Hot Sweats
  - Fatigue
  - Fever
  - Joints Swelling/Pain
  - Sleep Problems
- 7**
- Stress
  - Other \_\_\_\_\_
  - Other \_\_\_\_\_
  - Other \_\_\_\_\_



a wellness partnership

# Your History



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

| Medical History           |                          |                          |                          |                          |                          | Medical History               |                          |                          |                          |                          |                          |
|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                           | Self                     | Siblings                 | Mom                      | Dad                      | GPs                      |                               | Self                     | Siblings                 | Mom                      | Dad                      | GPs                      |
| ADD/ADHD.....             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS.....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol.....              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immune System - Weak.....     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies.....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel Syndrome..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis - Type.....     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease.....             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Birth Trauma.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lupus.....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Pressure.....       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mental Illness.....           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer - Type.....        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis.....       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cholesterol - High.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscular Dystrophy.....       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic Fatigue.....      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis.....             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Colitis.....              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever.....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions.....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever.....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression.....           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures.....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes.....             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shingles.....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug Addictions.....      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin Disorder.....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye Condition.....        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Disorder.....           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fibromyalgia.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke.....                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gall Bladder.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease.....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gastric/Reflux/Ulcer..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Varicose Veins.....           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glasses/contacts.....     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches.....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Weight Gain/Loss.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease.....        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other _____                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemorrhoids.....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other _____                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis.....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other _____                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Patterns   |               |
|--|---------------|
| <i>Mark those that apply and amount if applicable.</i> |               |
| <b>Example:</b> Lift Weights.....                      | <u>3 X wk</u> |
| Bowel movements.....                                   | _____         |
| Drive a stick shift.....                               | _____         |
| Eat out frequently.....                                | _____         |
| Enjoy work.....  | _____         |
| Exercise.....  | _____         |
| Healthy relationships.....                             | _____         |
| Lift weights.....                                      | _____         |
| Nicotine.....  | _____         |
| Phone work excessive.....                              | _____         |
| Skip meals.....  | _____         |
| Sleep comfortably.....                                 | _____         |
| Sleep on stomach.....                                  | _____         |
| Two story residence.....                               | _____         |
| Wear seat belts.....                                   | _____         |
| Work hours per week.....                               | _____         |

| Rate Your Activities   |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
| <i>Rate the degree of pain related to performing these activities.</i> |                          |                          |                          |
|  | <b>None</b>              | <b>Some</b>              | <b>Always</b>            |
| Climbing Stairs.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Computer work.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dressing.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Driving/riding in cars.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Getting in/out of cars.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Getting out of bed.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Using the restroom.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Housework.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Running.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexual Intercourse.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking care of child.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Yard work.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

© 2017 Your Wellness Connection. This form updated July 1st, 2017



a wellness partnership

# Your Life



Name: \_\_\_\_\_ Current Date: \_\_\_\_\_ Reassess Date: \_\_\_\_\_

**What is your story?** Take time to reflect on your life events from birth to the present time. What have your life events been? Start with birth moving through the life stages. Some examples are a difficult birth, accidents, marriage, divorce, deaths, starting a business, job changes, and financial issues.

**BIRTH TO 15 YEARS:** \_\_\_\_\_

\_\_\_\_\_

**15 TO 30 YEARS:** \_\_\_\_\_

\_\_\_\_\_

**30 TO 40 YEARS:** \_\_\_\_\_

\_\_\_\_\_

**40 TO 50 YEARS:** \_\_\_\_\_

\_\_\_\_\_

**50+ YEARS:** \_\_\_\_\_

| MY HYDRATION                                    |                        |
|---|------------------------|
| <i>What is your average daily intake? (oz.)</i> |                        |
| Water _____                                     | Alcohol _____          |
| Caffeine _____                                  | Soft Drinks _____      |
| Juice _____                                     | Energy Drinks _____    |
| Milk _____                                      | Other (write in) _____ |

| MY NUMBERS                             |                        |
|--|------------------------|
| <i>Please fill in the following...</i> |                        |
| Blood Pressure _____                   | Vitamin D Level _____  |
| Blood Sugar _____                      | Height _____           |
| Blood Type _____                       | Weight _____           |
| Cholesterol _____                      | Other (write in) _____ |

| MY FUEL   |  |
|---|--|
| <i>Think about how you eat in a typical week. Indicate what percent you eat of each of the following. (feel free to print this out and graph the chart)</i>   |  |
| <ul style="list-style-type: none"> <li>• Processed Foods<br/>% _____</li> <li>• Dairy<br/>% _____</li> <li>• Animal Protein<br/>% _____</li> <li>• Grains<br/>% _____</li> <li>• Fruits<br/>% _____</li> <li>• Vegetables<br/>% _____</li> <li>• Good Fats<br/>% _____</li> </ul> |  |

| MY WELLNESS PRACTICES                               |
|---|
| <i>In the past 3 years, have you had...</i>         |
| <input type="checkbox"/> Blood analysis / lab work  |
| <input type="checkbox"/> Blood pressure check       |
| <input type="checkbox"/> Bone density scan          |
| <input type="checkbox"/> Cardiovascular stress test |
| <input type="checkbox"/> Flexible sigmoidoscopy     |
| <input type="checkbox"/> Hearing test               |
| <input type="checkbox"/> Mammogram                  |
| <input type="checkbox"/> Pap/pelvic exam            |
| <input type="checkbox"/> Prostate exam              |
| <input type="checkbox"/> Spinal exam                |
| <input type="checkbox"/> Dental exam                |

| MY MEDICAL PRACTICES                                 |
|--|
| <i>Mark the wellness disciplines you use.</i>        |
| <input type="checkbox"/> Acupuncture                 |
| <input type="checkbox"/> Chiropractic                |
| <input type="checkbox"/> Dental Care                 |
| <input type="checkbox"/> Exercise / Movement Classes |
| <input type="checkbox"/> Eye Care                    |
| <input type="checkbox"/> General Medical             |
| <input type="checkbox"/> Massage Therapy             |
| <input type="checkbox"/> Meditation / Prayer         |
| <input type="checkbox"/> Nutritional Counseling      |
| <input type="checkbox"/> Psychological Counseling    |
| <input type="checkbox"/> Yoga                        |



a wellness partnership

# Body Talk

W5.1

Name: \_\_\_\_\_ Current Date: \_\_\_\_\_ Reassess Date: \_\_\_\_\_

List 3 major health goals.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Circle the appropriate number 0-3 on all questions below. 0 as the least/never to 3 as the most/always.

## DIGESTION

|   |          |          |          |          |
|---|----------|----------|----------|----------|
| <b>Alternating constipation and diarrhea</b> . . . . .                                    | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Diarrhea . . . . .  | 0        | 1        | 2        | 3        |
| <b>Constipation</b> . . . . .   | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Coated tongue or "fuzzy" debris on tongue . . . . .                                       | 0        | 1        | 2        | 3        |
| <b>Frequent use of laxatives</b> . . . . .  | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Stomach pain, burning or aching 1-4 hours after eating . . . . .                          | 0        | 1        | 2        | 3        |
| <b>Feeling hungry an hour or two after eating</b> . . . . .                               | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Temporary relief from antacids, food, milk, carbonated beverages . . . . .                | 0        | 1        | 2        | 3        |
| <b>Bitter metallic taste in mouth, especially in the morning</b> . . . . .                | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Unexplained itchy skin . . . . .  | 0        | 1        | 2        | 3        |
| <b>Stool color alternates from clay colored to normal brown.</b> . . . . .                | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Excessive belching, burping or bloating . . . . .   | 0        | 1        | 2        | 3        |
| <b>Difficulty digesting fruits/vegetables; undigested foods found in stools</b> . . . . . | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Roughage and fiber cause constipation . . . . .   | 0        | 1        | 2        | 3        |
| <b>Frequent urination.</b> . . . . .  | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Increased thirst and appetite . . . . .   | 0        | 1        | 2        | 3        |
| <b>History of gallbladder attacks or stones</b> . . . . .                                 | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Have you had your gallbladder removed? . . . . .  |          | yes      |          | no       |

## NERVOUS SYSTEM

|  |          |          |          |          |
|--|----------|----------|----------|----------|
| <b>Have difficulty falling asleep</b> . . . . .                      | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Have difficulty staying asleep; wake tired . . . . .                 | 0        | 1        | 2        | 3        |
| <b>Get ill often</b> . . . . .                                       | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Numbness and/or tingling in hands or feet . . . . .                  | 0        | 1        | 2        | 3        |
| <b>Frequent Headaches.</b> . . . . .                                 | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Limited flexibility . . . . .  | 0        | 1        | 2        | 3        |
| <b>History of severe falls</b> . . . . .                             | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Have poor concentration . . . . .                                    | 0        | 1        | 2        | 3        |
| <b>Wake up with pain.</b> . . . . .                                  | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Go to bed with pain . . . . .  | 0        | 1        | 2        | 3        |
| <b>Take over-the-counter pain medication</b> . . . . .               | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Take prescription pain medication . . . . .                          | 0        | 1        | 2        | 3        |
| <b>Multiple Accidents (car, bike, abuse)</b> . . . . .               | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Have a condition that is unidentified by my medical doctor . . . . . | 0        | 1        | 2        | 3        |

**(Continued on next page...)**

© 2017 Your Wellness Connection. This form updated July 1st, 2017



a wellness partnership

# Body Talk (continued...)

W5.2

## BLOOD SUGAR

|   |          |          |          |          |
|---|----------|----------|----------|----------|
| <b>Crave sweets during the day</b> . . . . .                        | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Irritable if meals are missed . . . . .                             | 0        | 1        | 2        | 3        |
| <b>Depend on coffee to keep yourself going or started</b> . . . . . | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Eating relieves fatigue . . . . .                                   | 0        | 1        | 2        | 3        |
| <b>Agitated, easily upset, nervous</b> . . . . .                    | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Poor memory, forgetful . . . . .                                    | 0        | 1        | 2        | 3        |
| <b>Blurred vision</b> . . . . .                                     | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Must have sweets after meals . . . . .                              | 0        | 1        | 2        | 3        |

## FEMALE HORMONES

|  |          |          |          |          |
|--|----------|----------|----------|----------|
| <b>Pain and cramping during periods</b> . . . . .      | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Breast pain and swelling during menses . . . . .       | 0        | 1        | 2        | 3        |
| <b>Irritable and depressed during menses</b> . . . . . | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Pelvic pain during menses . . . . .                    | 0        | 1        | 2        | 3        |
| <b>Acne break outs</b> . . . . .                       | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Hot flashes . . . . .                                  | 0        | 1        | 2        | 3        |
| <b>Mental fogginess</b> . . . . .                      | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Disinterest in sex . . . . .                           | 0        | 1        | 2        | 3        |
| <b>Mood swings</b> . . . . .                           | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Facial hair growth . . . . .                           | 0        | 1        | 2        | 3        |

## MALE HORMONES

|   |          |          |          |          |
|---|----------|----------|----------|----------|
| <b>Urination difficulty or dribbling</b> . . . . .      | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Frequent urination . . . . .                            | 0        | 1        | 2        | 3        |
| <b>Feeling of incomplete bowel evacuation</b> . . . . . | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Leg nervousness at night . . . . .                      | 0        | 1        | 2        | 3        |
| <b>Decrease in libido</b> . . . . .                     | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Decrease in fullness of erections . . . . .             | 0        | 1        | 2        | 3        |
| <b>Spells of mental fatigue</b> . . . . .               | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| Increase in fat distribution - chest and hips . . . . . | 0        | 1        | 2        | 3        |

## OTHER

|  |          |          |          |          |
|--|----------|----------|----------|----------|
| <b>I spend 2+ hours on social media daily</b> . . . . .              | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| I spend 2+ hours watching TV or playing video games . . . . .        | 0        | 1        | 2        | 3        |
| <b>I eat dinner or snacks after 8 PM regularly</b> . . . . .         | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| I regularly sleep less than 7 hours a night . . . . .                | 0        | 1        | 2        | 3        |
| <b>I have negative thoughts and feelings about my body</b> . . . . . | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| I smoke or use other tobacco/nicotine products . . . . .             | 0        | 1        | 2        | 3        |
| <b>I am concerned about my alcohol intake</b> . . . . .              | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |



- Mostly 2's and 3's: You need to stop, make a course correction and take action in that area
- Mostly 1's and 2's: You need to use caution, pay attention and start making changes in that area
- Mostly 0's and 1's: You're doing good in that area, keep moving

Think of it as if you are driving across country with a GPS. The more often you stop, pull off the road or take a detour (red), the more the GPS has to reroute itself. When the GPS is having to constantly recalculate and reroute, more energy is used, and your journey can become complicated. You need to make a course correction and take action to stay on the clearest route to wellness.



a wellness partnership

# Our Financial Policy

W6.1

It is the policy of this office that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments, regardless of whether or not this office accepts insurance assignment. All patients are responsible to check out with the front desk to satisfy any payment due at the time of the service.

## 1. Patients without Insurance:

All payments are expected at the time of service unless other arrangements are made with YWC. If an arrangement was made the payment for the service will be expected within 15 days of the service. If payment is not received within 15 days the balance due will be charged to the credit card listed on the credit card authorization that is listed at the end of this policy.

## 2. Patients with Insurance:

Deductibles, co-insurance and all co-payments, along with any services not covered by insurance are expected at the time of service. Unless other arrangement is made to delay this payment until the insurance company pays. Then the client will have 15 days to pay the balance due. If payment is not made in 15 days, the credit card listed on the credit card authorization that is listed at the end of this policy will be charged.

## 3. Purchase of Supplements, Supplies or Non Insurance Services:

All supplements, supplies and services not covered by insurance must be paid for at the time they are received. There are no exceptions on these items or services.

**ASSIGNMENT OF BENEFITS:** I, the undersigned, certify that I and/or my dependents have coverage with the insurance as presented to Your Wellness Connection PA and assign directly to Your Wellness Connection, PA all benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I acknowledge and understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

**AUTHORIZATIONS:** I hereby acknowledge that I have read the above policy regarding my financial responsibility to Your Wellness Connection PA for medical services and treatment provided and I agree to pay Your Wellness Connection PA any balance unpaid by my insurance carrier or not covered by an insurance carrier for myself and the person named below.

I hereby authorize Your Wellness Connection PA to charge my credit or debit card listed below for the full amount owed by me for all services and/or treatments, or supplements and supplies rendered by Your Wellness Connection PA in accordance with this agreement.

This authorization shall remain in effect unless and until it is revoked by you in writing and delivered to the office of Your Wellness Connection PA at 7410 Switzer Rd, Shawnee, KS 66203.

**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS:** I consent to the use or disclosure of my medical information by Your Wellness Connection (YWC) and/or the affiliate practitioners that operate within Your Wellness Connection, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of YWC. I understand that diagnosis or treatment of me by YWC may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. YWC is not required to agree to the restrictions that I may request. However, if YWC agrees to a restriction that I request, the restriction is binding on YWC. I have the right to revoke this consent, in writing, at any time, except to the extent YWC has taken action in reliance on this consent.

***(Continued on next page...)***

© 2017 Your Wellness Connection. This form updated July 1st, 2017

(913) 962-7408 (office) | (913) 962-7416 (fax) | 7410 Switzer, Shawnee, KS 66203 | [www.YourWellnessConnection.com](http://www.YourWellnessConnection.com)



a wellness partnership

# Our Financial Policy (continued...)

W6.2

My "medical 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 medical 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 understand I have a right to review YWC's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of YWC.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of YWC. This Notice of Privacy Practices also describes my rights and the duties of YWC with respect to my medical information. YWC 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 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printer Name:** \_\_\_\_\_

**Others covered by this agreement:** \_\_\_\_\_

### CREDIT CARD INFO

**Credit Card #** \_\_\_\_\_ **Card Type:** VISA MASTERCARD DISCOVER AMEX

**Expiration Date:** \_\_\_\_\_ **3-digit security code:** \_\_\_\_\_

**Name as it appears on card:** \_\_\_\_\_

**Address statement is sent to:** \_\_\_\_\_

**Authorization Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_





a wellness partnership

# Chiropractic Informed Consent



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Chiropractic evaluation and treatment involves certain inherent risks. There are several benefits associated with performing an evaluation. They include: working diagnosis of present condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. They include: increased flexibility, decreased pain, decreased inflammation, better circulation; all combining to improve function in activities of daily living.

Treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, acupuncture, and exercises. Risks may include but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability. However, any increase in the current level of discomfort, or any other change in symptoms should be immediately reported to a staff member.

**Adjustment:** Spinal manipulation that involves precise impulses in a specific direction to restore normal motion and position of individual vertebrae.

**Interferential current therapy:** Small electrical impulses are used to stimulate muscles and relieve tension by reducing nerve irritation. This current promotes the secretion of natural painkillers (endorphins).

**Intersegmental traction therapy:** This therapy utilizes rollers that slowly travel the length of the spine. By stretching individual joints, it promotes increased mobility and blood flow that leads to faster healing.

**Acupuncture:** This ancient Chinese practice using the insertion of needles is used to restore proper energy flow through the body known as Chi, the vital life energy that flows through every living thing.

**Exercise:** The entire body benefits from this therapy, both physically and psychologically. Exercise improves digestion, increases energy levels and promotes the reduction of stress.

Risk factors have been reduced to the best of our ability. Please acknowledge consent with full knowledge of the nature, risks, and purpose of the evaluation and treatment program.

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_