Waukee Wellness & Chiropractic, P.C.
DISCOVER YOUR HEALTH

Patient Information

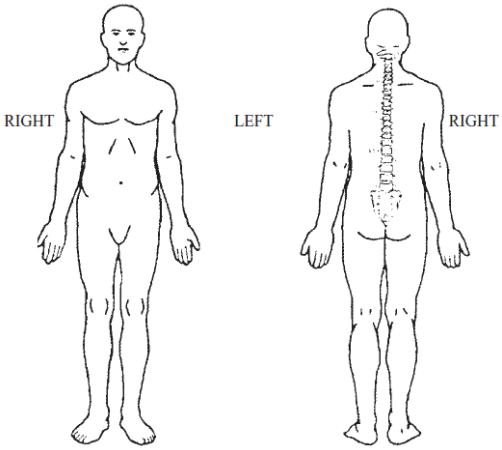
Patient ID #: _____

First Name: _____ **Last Name**: _____
Address: _____ **Date**: _____
City: _____ **State**: _____ **Zip**: _____
Home Phone: (_____) _____ **Cell Phone**: (_____) _____ **Work Phone**: (_____) _____
Birth date: _____ **Age**: _____ **Sex**: ○ M ○ F **SSN**: _____
Email Address: _____ **Preferred method of communication** *(Circle One)*: Phone / Email / Mail
Race *(Circle One)*: American Indian or Alaska Native / Asian / African American / Caucasian / Native Hawaiian or Pacific Islander / Other / I decline to answer
Ethnicity *(Circle One)*: Hispanic or Latino / Not Hispanic or Latino / I decline to answer
Smoking Status *(Circle One)*: Every Day Smoker / Occasional Smoker / Former Smoker / Never
Date you started smoking: _____ **Preferred Language**: _____
Occupation: _____ **Employer's Name**: _____
Work Address: _____ **City, State, and Zip**: _____
Marital Status: ○ S ○ M ○ D ○ W **Spouse's Name**: _____ **# of Children**: _____
How were you referred to Waukee Wellness? _____
Emergency Contact Name: _____ **Relation**: _____
Home Phone: (_____) _____ **Other Phone**: (_____) _____ **Email**: _____

Major Complaint Information

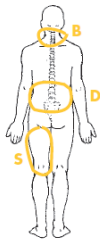
What is your major complaint? _____
When and how did this symptom(s) begin? _____
If this is an injury, please describe what happened: _____

Using the symbols provided in the Pain Index box, mark the areas on the illustrations below where you are experiencing pain.



Pain Index

D Dull Nagging Ache
B Burning
S Sharp / Stabbing
N Numbness / Tingling



For example: The image to the left illustrates a burning pain in the neck, a dull ache in the lower back, and a sharp pain in the left thigh.

What is the pain interfering with that's most important in your life? _____

Severity

On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain, please rate the severity of your pain:

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? ○ Yes ○ No If yes, when? _____
What aggravates this condition? _____
What decreases the symptoms/pain? _____

Waukee Wellness and Chiropractic
710 SE Alices Rd, Waukee, IA 50263
Ph: (515) 978-6661 Fax: (515) 978-6662

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DrWes@WaukeeWellness.com

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History

Have you seen another doctor for this condition? ○ Yes ○ No Date Consulted: _____
Doctor's Name: _____ Diagnosis: _____
Does it interfere with your sleep? ○ Yes ○ No How many times do you wake up in pain per night? _____
In what position do you sleep? ○ Back ○ Side ○ Stomach
Do you sleep with a pillow? ○ Yes ○ No How Many? _____
Does heat affect the pain? ○ Yes ○ No If so, how? _____
Does cold affect the pain? ○ Yes ○ No If so, how? _____
Do you wear a heal lift? ○ Yes ○ No If so, which side? ○ Right ○ Left
Does it cause pain to cough, grunt, or sneeze? ○ Yes ○ No If so, where? _____

Have you ever had any surgeries or hospitalizations? ○ Yes ○ No If yes, please list:

Type of Hospitalization/Surgery	Date	Type of Hospitalization/Surgery	Date

Have you been X-rayed / received an MRI or CAT scan in the last 12-18 months? ○ Yes ○ No When? _____
Have you been seen by a chiropractor before? ○ Yes ○ No Chiropractor/Office Name: _____
Do you have a family physician? ○ Yes ○ No Physician/Office Name: _____
If female, are you pregnant? ○ Yes ○ No If no or not sure, date of your last menstrual cycle: _____

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

Medication Name	Dosage (ex: 5mg)	Frequency (ex: once a day)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date: _____

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Medical Symptoms Questionnaire

Patient Name: _____ Date: _____

Rate each of the following symptoms based upon your typical health profile for the *past 30 days*:

Point Scale

0 – Never, or almost never, have this symptom
1 – Occasionally have it, effect is not severe
2 – Occasionally have it, effect is severe
3 – Frequently have it, effect is not severe
4 – Frequently have it, effect is severe

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

_____ **Total**

EYES
_____ Watery or Itchy Eyes
_____ Swollen, Reddened or Sticky Eyelids
_____ Bags or Dark Circles Under Eyes
_____ Blurred or Tunnel Vision
(Does not include near or far-sighted)
_____ **Total**

EARS
_____ Itchy Ears
_____ Earaches, Ear Infections
_____ Drainage from Ear
_____ Ringing in Ears, Hearing Loss

_____ **Total**

NOSE
_____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing Attacks
_____ Excessive Mucus Formation

_____ **Total**

MOUTH/THROAT
_____ Chronic Coughing
_____ Gagging, Frequent Need to Clear Throat
_____ Sore Throat, Hoarseness, Loss of Voice
_____ Swollen/Discolored Tongue, Gums, or Lips
_____ Canker Sores

_____ **Total**

HEART
_____ Irregular or Skipped Heartbeat
_____ Rapid or Pounding Heartbeat
_____ Chest Pain

_____ **Total**

LUNGS
_____ Chest Congestion
_____ Asthma, Bronchitis
_____ Shortness of Breath
_____ Difficulty Breathing

_____ **Total**

OTHER
_____ Frequent Illness
_____ Frequent or Urgent Urination
_____ Genital Itch or Discharge

_____ **Total**

JOINTS/MUSCLE
_____ Pain or Aches in Joints
_____ Arthritis
_____ Stiffness or Limitation of Movement
_____ Pain or Aches in Muscles
_____ Feeling of Weakness or Tiredness

_____ **Total**

SKIN
_____ Acne
_____ Hives, Rashes, Dry Skin
_____ Hair Loss
_____ Flushing, Hot Flashes
_____ Excessive Sweating

_____ **Total**

WEIGHT
_____ Binge Eating/Drinking
_____ Craving Certain Foods
_____ Excessive Weight
_____ Compulsive Eating
_____ Water Retention
_____ Underweight

_____ **Total**

ENERGY/ACTIVITY
_____ Fatigue, Sluggishness
_____ Apathy, Lethargy
_____ Hyperactivity
_____ Restlessness

_____ **Total**

MIND
_____ Poor Memory
_____ Confusion, Poor Comprehension
_____ Poor Concentration
_____ Poor Physical Condition
_____ Difficulty in Making Decisions
_____ Stuttering or Stammering
_____ Slurred Speech
_____ Learning Disabilities

_____ **Total**

EMOTIONS
_____ Mood Swings
_____ Anxiety, Fear, Nervousness
_____ Anger, Irritability, Aggressiveness
_____ Depression

_____ **Total**

DIGESTIVE TRACT
_____ Nausea, Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated Feeling
_____ Belching, Passing Gas
_____ Heartburn
_____ Intestinal/Stomach Pain

_____ **Total**

GRAND TOTAL _____

Waukee Wellness & Chiropractic, P.C.
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OSWESTRY Questionnaire

Name: _____ **Date:** _____

SECTION 1 - PAIN INTENSITY
(0 pts) I can tolerate the pain that I have without the use of medication.
(1 pts) The pain is bad but I manage without taking pain medication.
(2 pts) Pain medication gives me complete relief from pain.
(3 pts) Pain medication gives me moderate relief from pain.
(4 pts) Pain medication gives me very little relief from pain.
(5 pts) Pain medication has no effect on the pain and I do not use it.

SECTION 2 - PERSONAL CARE (Washing, Dressing, etc.)
(0 pts) I can take care of myself normally without an increase in pain.
(1 pts) I can look after myself normally but it causes an increase in pain.
(2 pts) It is painful to care for myself, requiring me to be slow and careful.
(3 pts) I need some help but manage most of my personal care.
(4 pts) I need help every day in most aspects of self-care.
(5pts) I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 - LIFTING
(0 pts) I can lift heavy weights without increasing my pain.
(1 pts) I can lift heavy weights but it does increase my pain.
(2 pts) Pain prevents me from lifting heavy weights off the floor, but I can manage if conveniently positioned, e.g., on a table.
(3 pts) Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if conveniently positioned.
(4 pts) I can lift only very light weights.
(5 pts) I cannot lift or carry anything at all.

SECTION 4 - WALKING
(0 pts) Pain does not prevent me from walking any distance.
(1 pts) Pain prevents me from walking more than one mile.
(2 pts) Pain prevents me from walking more than 1/2 mile.
(3 pts) Pain prevents me from walking more than 1/4 mile.
(4 pts) I can only walk using a cane or crutches.
(5 pts) I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - SITTING
(0 pts) I can sit on any chair as long as I want.
(1 pts) I can only sit in my favorite chair as long as I like.
(2 pts) Pain prevents me from sitting more than one hour.
(3 pts) Pain prevents me from sitting more than 1/2 hour.
(4 pts) Pain prevents me from sitting more than 10 minutes.
(5 pts) Pain prevents me from sitting at all.

Total: _____ **x's 2 =** _____

SECTION 6 - STANDING
(0 pts) I can stand as long as I like without increasing my pain
(1 pts) I can stand as long as I like but it increases my pain.
(2 pts) Pain prevents me from standing for more than one hour.
(3 pts) Pain prevents me from standing for more than 30 minutes
(4 pts) Pain prevents me from standing for more than 10 minutes
(5 pts) Pain prevents me from standing at all.

SECTION 7 - SLEEPING
(0 pts) Pain does not prevent me from sleeping well.
(1 pts) I can sleep well only using medication.
(2 pts) Even when I take medication, I get less than 6 hours of sleep.
(3 pts) Even when I take medication, I have less than 4 hours of sleep.
(4 pts) Even when I take medication, I have less than 2 hours of sleep.
(5 pts) Pain prevents me from sleeping at all

SECTION 8 – SEX LIFE
(0 pts) My sex life is normal and causes no increase in my pain.
(1 pts) My sex life is normal but causes some increase in my pain.
(2 pts) My sex life is nearly normal but is very painful.
(3 pts) My sex life is severely restricted by my pain.
(4 pts) My sex life is nearly absent because of my pain.
(5 pts) Pain prevents any sex life at all.

SECTION 9 – SOCIAL LIFE
(0 pts) My social life is normal and does not increase my pain.
(1 pts) My social life is normal but increases my pain.
(2 pts) My pain has no effect on my social life apart from limiting my more energetic interests, such as dancing.
(3 pts) Pain has restricted my social life and I do not go out as often.
(4 pts) Pain has restricted my social life to my home.
(5 pts) I have no social life because of my pain.

SECTION 10 - TRAVELING
(0 pts) I can travel anywhere without increasing my pain.
(1 pts) I can travel anywhere but it increases my pain.
(2 pts) My pain is bad but I manage trips over two hours.
(3 pts) My pain restricts me to journeys of less than one hour.
(4 pts) My pain restricts me to short, necessary trips under 30 minutes.
(5 pts) My pain prevents me from traveling except to my medical appointments or to the hospital

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Financial Policy

Dear Patient,

Here at Waukee Wellness & Chiropractic we provide our services directly to you, not your insurance company. You are ultimately responsible for your bill. If you are submitting your own claims we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered, provided that your deductible, co-insurance, and/or copay for said services have been paid. In the event that we are billing your insurance and a check is mailed to you, you MUST bring the payment to the office within 7 days so that we may properly credit your account. If your insurance carrier has not paid a claim within 90 days of submission, you accept responsibility for payment in full of the outstanding balance. ***You are required to inform us of any and all insurance changes within 30 days. You will be responsible for any outstanding charges accumulated during your insurance lapse***. If your balance reaches $100 and there is no payment plan scheduled, we hold the right to not provide service to you until payment is made or a payment plan is in place. If you discontinue care for any reason, all balances become immediately due and payable in full by you, regardless of any claim(s) submitted. If your account enters into a default status and is considered past due, you assume and agree to pay any administrative fees that may be associated with the collections process. (A default account is deemed when your patient balance is $100 or more or any amount 90 days past due.)

Patient Signature: _____ Date: _____

Financial Counselor (if applicable): _____

X-Ray

I hereby give my consent to Waukee Wellness & Chiropractic and its representatives to take x-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

Patient Signature: _____ Date: _____

Informed Consent for Chiropractic Care

As a patient coming to Waukee Wellness & Chiropractic you give the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are regularly beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or healthcare if he is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicated healthcare service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime. I understand that if I am accepted as a patient by Waukee Wellness & Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding Chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____

Guardian Signature (if patient is under 18): _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require that you read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to ask and we will provide you with that information.

1. The patient understands and agrees to allow Waukee Wellness & Chiropractic to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent needs only to be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For the patient's security and right to privacy, all staff members have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my PHI will be used and I agree to these policies and procedures.
Patient Signature: _____ Date: _____
Guardian Signature (if patient is under 18): _____

Terms of Use for Waukee Wellness & Chiropractic Social Media

I consent for photographs and/or video images to be taken of me by WW&C, PC. or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated by any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images: (please initial at YES or NO below) _____ YES _____ NO

For educational purposes (medical teaching or training), _____ YES _____ NO

For marketing and advertising purposes (website, print, digital, or social media), _____ YES _____ NO

At my request, my photographs and/or video images will only be used as part of my medical record. I hereby release Waukee Wellness & Chiropractic., its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation. By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to WW&C, PC. or by completion of a new form.

Please sign that you have read and understand the previous information regarding social media in our office.
Printed Name: _____ Date: _____
Signature: _____