Dr. T Wellness

6565 Kimball Dr. #101
Gig Harbor, WA 98335
Phone 253.377.1800, www.drtwellness.com

About You

Name_____ Age_____ Date_____

Cell Phone_____ Carrier_____

Address_____ City_____State_____Zip_____

Email Address_____

Gender ☐ Female ☐ Male Marital Status_____ Birthdate_____

Height_____ Weight_____ Physicians Name_____

I give permission to Tacoma Chiropractic Health Center to send a brief progress report to my physician._____Initial Please

Occupation_____Type of Work_____

Employer_____

Emergency Contact_____Phone Number_____

Relationship to Emergency Contact_____

About Your Spouse/Significant Other or Parents and Family

Name_____Employer_____Work Phone_____

Number of Children_____ Names and Ages_____

Consultation

I'm interested in:

☐ Support for a healthy lifestyle ☐Coaching ☐Massage Therapy
☐Nutritional Supplements ☐Chiropractic Care

Experience with Chiropractic

Who referred you to this office?_____Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

If yes, reason for the visit_____

Doctor's Name_____Approximate Date of Last Visit_____

Name_____ Date_____

Reason For Visit

Is this visit for a specific health condition or wellness? If yes Please describe _____

When did this condition begin? _____The Condition has: ☐ Gotten Worse ☐Stayed Constant ☐ Comes and Goes

Does this condition interfere with your work, sleep, daily routine, or other activities? ☐ Yes ☐ No

Has this condition occurred before? ☐ Yes ☐ No Please Explain _____

Have you seen other doctors for this condition? ☐ Yes ☐ No Doctors Name _____

What makes your condition Better? _____Worse? _____

Type of Treatment_____ Results_____

Have you been involved in a motor vehicle accident within the last 12 months? ☐ Yes ☐ No

Have you been involved in a slip and fall or PI claim within the last 12 months? ☐ Yes ☐ No

Please explain: _____

Health History

Have you ever had surgery or been hospitalized? ☐ Yes ☐ No

If yes Please explain _____

When was the last time you had a spinal x-ray? _____

What medications are you currently taking? _____

What supplements are you currently taking? (i.e. vitamins, herbs)? _____

Are you aware of any poor postural habits? _____

How do you sleep (i.e. right side, left side, back, stomach)? _____

Do you have allergies to anything? Please List _____-_

Family / Personal History List any conditions i.e. cancer, heart disease etc..._____

Do you smoke? _____ if yes, how many per day? _____

Do you drink alcohol? _____ if yes, how many drinks per week? _____

Do you drink coffee? _____ if yes, how many cups per day? _____

Do you exercise regularly? _____ if yes, how many times per week? _____

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Name_____ Date_____

Survey of Overall Health

Please check each of the diseases or conditions that the patient has nor or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall care plan.

☐ Headaches	☐Heart Defect	☐Shingles	**For Women**	
☐ Sinus Problems	☐Heart Surgery/	☐Kidney Problems	Are you Pregnant?	☐Yes ☐No
☐Dizziness	pacemaker	☐Hepititis	Are you Nursing ?	☐Yes ☐No
☐Loss of Sleep	☐High / Low	☐Cancer	Are you taking birth control?	☐Yes ☐No
☐Pain between shoulders	Blood Pressure	☐Anemia	Do you have irregular cycles ?	☐Yes☐No
☐Jaw pain/clicking	☐Difficulty Breathing	☐Rheumatic Fever	Do you have Breast implants?	☐Yes☐No
☐Numbness or Pain	☐Asthma	☐Psychiatric Problems		
in Arms/Hands/legs	☐Arthritis	☐ Thyroid Problems		
☐Sexual Dysfunction	☐Alcohol/ Drug Abuse	☐Neck Pain		
☐Digestive Problems	☐HIV/Aids	☐Upper Back Pain		
☐Ulcers/Colitis	☐Diabetes	☐Mid Back Pain		
☐Heart Attack/stroke	☐Tuberculosis	☐Lower Back Pain		

Please list any health conditions not mentioned

_____

_____

Goals for my Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others For corrections of whatever is malfunction in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief Care** – Symptomatic relief of pain and discomfort

☐ **Corrective Care** – Correcting and relieveing the cause of the problem as well as the pain and symptoms

☐ **Comprehensive Care** – Bring whatever is malfunctioning in the body to the highest state of health possible.

☐ I want the Doctor to select the type of care appropriate for my condition

Name _____ Date_____

Terms of Acceptance

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working from the same goals. Chiropractic does not diagnose or treat disease. Chiropractic has only one goal:

TO LOCATE , ANALYZE, AND CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM.

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system Automatically produces improper function in the body. The Subluxation(Spinal misalignment producing nerve Interference), in and of itself, is a detriment to life and health. Correction of the subluxation through specific chiropractic Adjustment allows the body to function at it's optimum level. This allows the innate healing power of the body to work At maximum efficiency to restore, maintain, and promote natural health.

WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.
WE OFFER NO TREATMENT OF CONDITON(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.
WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S)
THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!

I, _____ having read the above statement, and understanding it fully, do Undertake chiropractic health care on this basis.

Date:_____ SIGNATURE_____

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems Appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am Personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not Be held responsible for any pre- existing medically diagnosed conditions nor for any medical diagnosis. I also understand This if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and Payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider for Services rendered.

Notice of Privacy Practices (NOPP) Acknowledgement: I acknowledge that I have read and understood the Notice of Privacy Practices Policy at Tacoma Chiropractic Health Center.

_____ _____

Patient Signature Date Guardian or Spouse Signature Authorizing Care Date

Who should receive bills for payment on your account? ☐ Patient ☐ Spouse ☐ Parent ☐ Work Comp ☐ Auto Claim