



East Wellness

Today's Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address _____ City: _____ State: _____ Zip: _____

Date of Birth: ___/___/___ Email address: _____

Home Phone: _____ Cell Phone : _____ Work Phone: _____

How did you hear about our office? _____

Would you prefer appointment reminders by (Please circle): Text Email Phone Call If
you would like text reminders, please tell us your cell phone carrier: _____

Occupation: _____ Employer: _____ In Case of
Emergency Call: _____ Phone #: _____

Please Circle your Confidential Communication Preference: Home # Cell # Email

If patient is a MINOR, who is the account's responsible party?

Name: _____ Address: _____ Phone: _____

Which services are you seeking in our office today? (Please Circle)

Chiropractic Services

Injectable/IV nutrient therapy

NAET Allergy Elimination

Weight Loss Management

Nutritional Counseling

Name: _____ Date: _____

Please list any additional Current Health Concerns:

Muscles, Bones, Joints: _____

Nerves, Headaches, Dizziness or Emotional: _____

Head, Eyes, Ears, Nose, Throat: _____

Heart, Blood Pressure, or Circulation: _____

Shortness of breath, Cough, Asthma/other Lung issues: _____

Stomach, Bowels or Digestive Conditions: _____

Genital, Bladder, or Urinary Conditions: _____

Diabetes, Thyroid, or Glandular Conditions: _____

Skin or Bleeding Conditions: _____

Allergies or Sensitivities: _____

Please List any Surgeries (procedure and year performed):

Please list current medications/supplements you are taking:

Please list any accidents you were in (e.g. work or auto accidents-include date of accidents):

Please circle any of the following illnesses within your immediate family (mom, dad, siblings):

Cancer Heart Disease Diabetes Neurological disorders Psychological disorders

Stroke Kidney Disorders Lung Disorders None of the Above

Please circle Work Status that best applies to you:

Full time Part time Retired Stay at home Unemployed Disabled Student

Please circle any current social habits that apply to you:

Drinks alcohol Drinks caffeine Uses tobacco Uses recreational drugs None

Please circle typical exercise habits that best applies to you:

Daily exercise 2-3 times/wk exercise 1/wk exercise Seldom exercise No exercise

Please Circle Yes or No to the following: Pregnant? Y N If so, How far along? _____

Metal Implant? Y N Breast Implants? Y N Been Gunshot? Y N Have Pacemaker? Y N

Patient Consent for Services

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I give East Wellness my consent to collect and use the above information. I authorize the office of East Wellness and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Name (Printed): _____

Patient/Guardian Signature: _____ Date: _____

Acknowledgement of Notice of Privacy Practices

I acknowledge that a copy of this clinic’s Notice of Privacy Practices has been made available to me. I also understand that this Notice is available by request.

Name of Patient or Legal Representative Date

Signature of Patient or Legal Representative Date

For Office Use Only: We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because: _____

Staff Signature: _____ Date: _____