WAUTIER WELLNESS
CHIROPRACTIC
WAUTIERWELLNESS.COM

Patient Information and History

Patient Information

Name _____
(First) (Initial) (Last) (Name called by)
Address _____
Birthday _____ Age _____
☐ Male ☐ Female Social Security # _____
Occupation _____ Employer _____
Home phone _____ Work phone _____
Cell phone _____
Parent Name (if minor) _____
Single Married Divorced Widowed Separated
Spouse's Name _____
# of Children _____ Names _____

Insurance

Who is responsible for this account? _____
Relationship to this patient? _____
Insurance Company _____
Insurance ID Number _____
Group/Claim Number _____
Birth Date _____
Is the patient covered by additional insurance?
☐ Yes ☐ No
Insurance Company _____
Subscriber # and Name _____
Group # _____

Please present insurance card(s) so we can include a copy in your file.

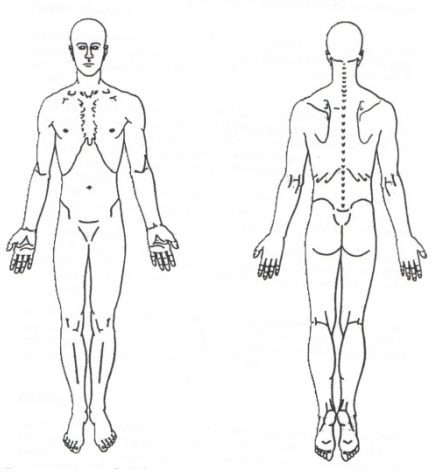
Patient's Condition

What is your major symptom/problem? _____
When did your symptoms begin? _____
Was this caused from an accident? _____
Type of Accident: Automobile Home Work Other _____
Have you had this problem before? _____
Is your condition getting progressively worse? ☐ Yes ☐ No
Is this problem ☐ constant ☐ comes and goes
How does it feel? Achy Burning Sharp Shooting Dull Stiff
Tingling Throbbing Swelling Other _____
Rate your level of pain (circle number below)
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
What makes your condition better? _____
What makes your condition worse? _____
Does it interfere with your: work sleep daily routine recreation
Actives/Movement that are painful to perform:
Sitting Standing Walking Bending Lying down
Driving Getting up Other

Emergency Contact

Name _____
Relationship to patient _____
Phone number to best reach them
_____

Please indicate on the diagram the location(s) of your pain.



———Stephanie Wautier, RN, BSN, DC———
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www.wautierwellness.com

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Health History

What other treatments have you had for this condition? _____

Name of doctors who have treated you for this _____

Have you had any previous chiropractic care? ☐ Yes ☐ No Date _____ ☐ Local ☐ Out of State

Date of last: Physical Exam_____ Spinal Exam _____ Spinal X-Ray _____ MRI _____ CT Scan _____

Who is your primary care doctor? _____ Any drug allergies? _____

List any medications you are taking _____

Vitamins/Herbs/Minerals _____

Females: Are you pregnant? ☐ Yes ☐ No Beginning of last menstrual cycle _____

Check any of the following conditions you have had:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anxiety/Depression
- ☐ Arm/shoulder pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder problems
- ☐ Cancer
- ☐ Chronic fatigue
- ☐ Deafness
- ☐ Diabetes
- ☐ Digestion problems
- ☐ Earache
- ☐ Ear ringing
- ☐ Epilepsy
- ☐ Headaches
- ☐ Headaches - Migraine
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Herniated disk
- ☐ High blood pressure
- ☐ Insomnia
- ☐ Irregular cycle
- ☐ Kidney problems
- ☐ Leg pain
- ☐ Low back pain
- ☐ Neck pain
- ☐ Osteoporosis
- ☐ Poor circulation
- ☐ Prostate problems
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Shingles
- ☐ Sinus infection
- ☐ Stroke
- ☐ Thyroid problems
- ☐ TMJ
- ☐ Venereal disease
- ☐ Vertigo/Dizziness

STRESSORS

- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/ Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Height _____

Weight _____

Blood Pressure _____

Have you had any:	Description	Date
Automobile Accidents		
Surgeries		
Broken Bones		
Falls/ Head Injuries		

Authorization

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not pain by insurance. I authorize Wautier Wellness, Inc./Stephanie Wautier, D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_____

Signature Date Parent (if minor)

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