Welcome to DREAM Wellness!

Please fill out our Health & Wellness Record as completely and accurately as possible. If you have any questions, please do not hesitate to ask one of our qualified Office Coordinators.

It is our pleasure to be of service to you.
Our commitment to you is to promote the highest quality of wellness services and classes.

About You (the Practice Member)

Name _____
Address _____
City _____ State_____ Zip_____
Home Phone (_____)_____
Cell Phone (_____)_____
Birth date_____ Age _____
Gender ❒M ❒ F Number of Children _____
Employer _____
Work Address _____
Work Phone _____
Occupation _____

Marital Status ❒Married ❒Single ❒ Divorced
❒Separated ❒ Widowed
Would you like to receive newsletters? ❒Yes ❒No
Email Address _____
The best way to contact you: Home/Cell/Work

For appointment reminders, is it ok to text your cell phone? ❒ Yes ❒ No Who is your carrier? _____

About the Spouse or Parent

Name _____
Employer _____
Work Address _____
Work Phone _____
Type of Work _____

Reason For This Visit

Describe the purpose of this visit: _____
_____

If you are here due to an injury, is it related to:
(If there is no injury, skip this section)
❒ Job ❒ Sports ❒ Auto ❒ Fall
❒ Chronic Discomfort ❒ Home Injury ❒ Other
Please explain _____

If job related, have you made a report of your accident to your employer? ❒ Yes ❒ No

When did this condition begin? _____

Has this condition ❒ gotten worse
❒ stayed constant ❒ comes and goes

Does this condition interfere with
❒ work ❒ sleep ❒ Daily Routine ❒ Other activities
Please explain _____

Has this condition occurred before? ❒ Yes ❒ No
Explain _____

Have you seen other doctors for this condition?
❒ Yes ❒ No

Dr.'s Name (s) _____
Type of Care _____
Results _____

Experience with Wellness

Who may we thank for referring you to this office? _____
What type of wellness providers have you been to before? (Make a check mark ✓if in past, circle ❍ if current)
❒ Chiropractor ❒ Massage Therapist ❒ Nutritionist ❒ Acupuncturist ❒ Personal Trainer/Fitness Expert
❒ MAT Specialist ❒ Life Coach ❒ Other _____
What type of fitness have you participated in before? (Make a check mark if in past, circle if current & regular)
❒ Yoga ❒ Pilates ❒ Tai Chi ❒ Weight Lifting ❒ Martial Arts ❒ Running/Jogging ❒ Meditation ❒ Aerobics
❒ Cycling/Spinning classes ❒ Dance ❒ Plyometrics ❒ Other _____
Do you currently belong to a health club? ❒ Yes ❒ No
If no, would you be interested in learning how you can join one at a reduced rate? ❒ Yes ❒ No
Do you currently consume at least 8-10 servings of fruits and vegetables daily? ❒ Yes ❒ No

Awareness of Your Body

Were you aware that…
The central nervous system (CNS) controls all bodily functions and systems? ❒ Yes ❒ No
Your CNS must be free of interference for optimal health and wellness to exist? ❒ Yes ❒ No

Have you had your nerve system checked for interference in the past 6 months? ❒Yes ❒ No

If yes, when and by whom? _____

Goals For My Care

People see wellness providers for a variety of reasons. Some go in the absence of symptoms and to promote wellness throughout a lifetime. Others go for the **relief** of pain/symptoms. Then there are some who go to **correct** the **cause** of their pain/symptoms. Your provider will weigh **your needs and desires** when recommending care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ❒ **Relief Care**: Symptomatic relief of pain or discomfort only
- ❒ **Corrective Care**: Correcting the cause of the problem as well as relieving the symptoms.
- ❒ **Comprehensive Care**: Bring whatever may be malfunctioning in the body to the highest state of health possible with wellness care (This includes Relief & Corrective Care if necessary).
- ❒ I want my wellness provider to select the type of care appropriate for me.

_____

Practice Member's Signature Date

Medications I Now Take

❒ Nerve Pills
❒ Pain Killers (including Aspirins)
❒ Muscle Relaxers
❒ Blood Pressure Medicine
❒ Insulin
❒ Stimulants
❒ Blood Thinners
❒ Tranquilizers
❒ _____
❒ _____

Health Habits

	No	Yes
Do you smoke?	❒	❒
Do you drink alcohol?	❒	❒
Do you drink coffee?	❒	❒

Do you exercise regularly? ❒ No ❒ Moderate ❒ Daily

Do you wear ❒ Heel Lifts ❒ Sole lifts ❒ Inner Soles ❒ Arch Supports

HEALTH CONDITIONS

Please check each of the diseases or conditions that you have **now** or had in the **past**. While they may seem unrelated to the purpose of the appointment, they can affect on your care.

❒Headaches
❒Sinus Problems
❒Dizziness
❒Cancer
❒Loss of Sleep
❒Hepatitis
❒Discomfort Between the Shoulders
❒Frequent Neck Pain
❒Drug/Alcohol Dependency
❒Arms/Legs/Hands Pain or Numbness
❒Lower Back Problems
❒Digestive Problems
❒Ulcers/Colitis
❒Heart Attack/Stroke
❒Thyroid Problems
❒Kidney Problems
❒Other_____

❒Congenital Heart Defect
❒Heart Surgery/Pacemaker
❒High/low Blood Pressure
❒Psychiatric Problems
❒Difficulty Breathing
❒Rheumatic Fever
❒Asthma
❒Arthritis
❒Tobacco Usage
❒Venereal Disease
❒HIV/AIDS
❒Diabetes
❒Tuberculosis
❒Shingles
❒Chemotherapy
❒Anemia
❒Other_____

FOR WOMEN ONLY:

Are you pregnant? ❒Yes ❒No
Any Possibility? ❒Yes ❒No
Are you nursing? ❒Yes ❒No
Are you taking birth control pills? ❒Yes ❒No
Do you experience painful periods? ❒Yes ❒No
Do you have irregular cycles? ❒Yes ❒No
Do you have breast implants? ❒Yes ❒No

AUTHORIZATION FOR CARE

I hereby authorize the providers at DREAM Wellness to work with me through the use of procedures and techniques he/she is certified and/or licensed and qualified for, as he/she deems appropriate.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. DREAM Wellness will not be held responsible for any pre-existing medically diagnosed conditions or for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

_____ _____

Practice Member Signature Date Guardian or Spouse's Signature Date

Who should receive bills for payment due on your account?

❒Self ❒Spouse ❒Parent ❒Worker's Comp.
❒Medicare ❒Personal Health Insurance ❒Auto Insurance

Ownership of X-ray Films

It is understood and agreed that the payments to DREAM Wellness for X-Rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time. If I desire a copy of my films, they will provided to at the cost incurred to DREAM Wellness.

Emergency Contact

Name _____

Relationship _____

Work Phone _____

Home Phone _____

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that DREAM Wellness will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to DREAM Wellness will be credited to my account upon receipt.

Insurance Company _____ Policy #_____
Address_____ Group # _____
Phone Number_____

ABOUT THE INSURED PERSON

Name _____ Insured's Social Security #_____
Relation _____ Date of Birth _____