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# Welcome to DREAM Wellness!

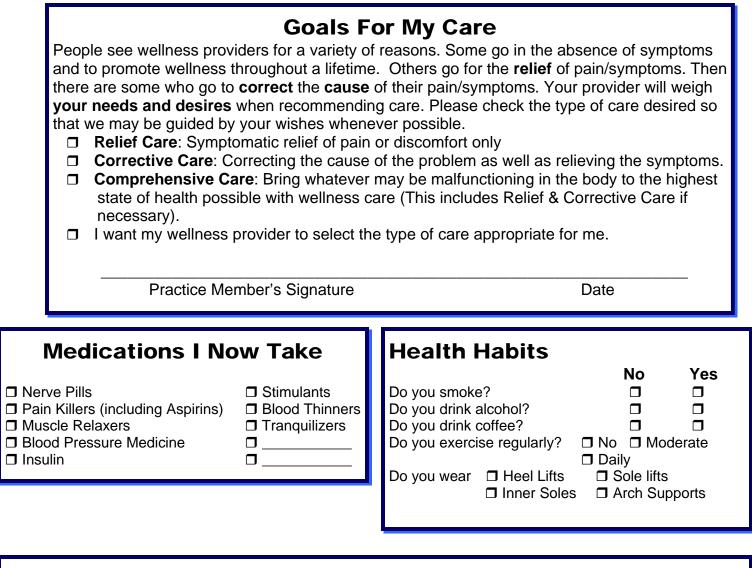
Please fill out our Health & Wellness Record as completely and accurately as possible. If you have any questions, please do not hesitate to ask one of our qualified Office Coordinators.

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   IM   F   Number of Children   Employer   Work Address   Work Phone   Occupation	Reason For This Visit         Describe the purpose of this visit:	
Marital Status	Has this condition	
About the Spouse or Parent         Name         Employer         Work Address         Work Phone         Type of Work	Has this condition occurred before? Explain	

## **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 O if current)
Chiropractor I Massage Therapist I Nutritionist I Acupuncturist I 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?
If no, would you be interested in learning how you can join one at a reduced rate?
Do you currently consume at least 8-10 servings of fruits and vegetables daily?  Yes  No
Awareness of Your Body
Awareness or rour body
Were you aware that The central nervous system (CNS) controls all bodily functions and systems? Yes I No Your CNS must be free of interference for entimal health and wellness to exist?
Your CNS must be free of interference for optimal health and wellness to exist?
Have you had your nerve system checked for interference in the past 6 months? TYes D No
If yes, when and by whom?



#### **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	<ul> <li>Congenital Heart Defect</li> <li>Heart Surgery/Pacemake</li> </ul>	FOR WOMEN ONLY:
Dizziness	□High/low Blood Pressure	Are you pregnant? Any Possibility?
□Cancer	Psychiatric Problems	□Yes □No □Yes □No
□Loss of Sleep	Difficulty Breathing	Are you nursing?
□Hepatitis	CRheumatic Fever	□Yes □No
Discomfort Between the Shoulders	□Asthma	Are you taking birth control pills?
Frequent Neck Pain	□Arthritis	□Yes □No
Drug/Alcohol Dependency	□Tobacco Usage	Do you experience painful periods?
□Arms/Legs/Hands Pain or Numbness	Venereal Disease	□Yes □No
□Lower Back Problems	□HIV/AIDS	Do you have irregular cycles?
Digestive Problems	Diabetes	□Yes □No
□Ulcers/Colitis	Tuberculosis	Do you have breast implants?
□Heart Attack/Stroke	⊐Shingles	□Yes □No
□Thyroid Problems	Chemotherapy	
☐Kidney Problems	□Anemia	
□Other	□Other	

#### **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.

	Policy # Group #
	BOUT THE INSURED PERSON
Name Relation	Insured's Social Security # Date of Birth