the wellness place

Welcome To Our Office

Thank you for choosing our office. Attached are the forms we need to help us assess your overall health and wellness. Please carefully complete them and bring them with on your visit to the office.

The Wellness Place is unique in this community. Our center is wellness centered Chiropractic practice for the health conscious, wellness minded individual and their families. We strive to improve the overall health and well-being of our patients, as well as preventing health problems so that our patients may live a more vital life. Unlike other Chiropractors who focus on back pain and neck pain and limit care to symptoms, we focus on the individual's health potential and provide a unique wellness experience.

I look forward to meeting you,

Dr. Greg Anderson

Dr. Greg Anderson, Chiropractor
The Wellness Place

210 E. Clark Avenue, Suite A
Santa Maria, CA 93455
(805) 934-5671

175 McMurray Road, Suite G
Buellton, CA 93427
(805) 698-1332

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Confidential Chiropractic Questionnaire

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Referred to office by: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: (H) _____ (W) _____ (Cell) _____

Email Address: _____ Social Security #:_____

Marital Status: S M D W Spouse's Name:_____

Children ☐ Yes ☐ No Ages: _____

Occupation: _____ Employer: _____ Hours worked/wk: ___

Health Information:

What are your **objectives** in consulting our office? _____

What are your **health goals** once these objectives have been met? _____
_____

Do you **presently** have any health problems, major or minor complaints? ☐ No ☐ Yes If yes, explain: _____
_____

When did this problem start and **how long** have you had this? _____

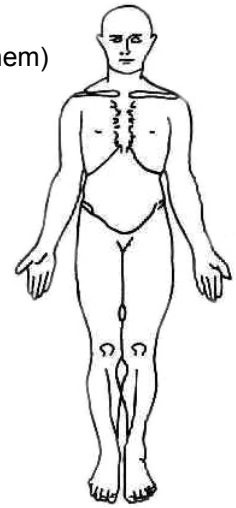
Current Health:

What are your most pressing health concerns? _____
_____

Is it ☐ getting worse ☐ improving ☐ intermittent ☐ constant

Where is the problem?
(Mark diagrams and label them)

Right



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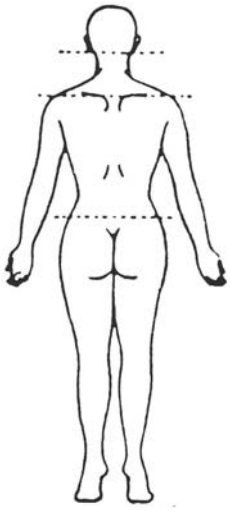

Right

Do you have: ☐ Pain ☐ Numbness ☐ Tingling ☐ Aches

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Is your pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Constant ☐ Intermittent

Are your symptoms worsened by: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Weather

Please explain: _____

Do you feel: ☐ Cramps ☐ Burning ☐ Swelling ☐ Stiffness ☐ Other _____

Do your symptoms interfere with: ☐ Work ☐ Day-to-day activities ☐ Sleep ☐ Play ☐ Other _____

On a scale of 1-10 (1= least, 10= most) please rate:

The severity of your symptoms: 1 2 3 4 5 6 7 8 9 10

Have you had previous care for this condition? ☐ No ☐ Yes

Who was the last doctor who created a health development plan for you, if any? _____

Did you follow all of the Doctor's recommendations? ☐ Yes ☐ No ☐ I was never put on a health plan

How long were you able to stay on the health development plan? _____

What were the results, if any? _____

What other wellness professionals are currently a part of your health care team?
☐ Massage therapist ☐ Acupuncturist ☐ Naturopath ☐ Homeopath ☐ Nutritionist ☐ Other _____

How many Medical Doctor's office visits did you and your family have last year?
☐ None ☐ Less than 5 ☐ Between 5-10 ☐ More than 10

Have you had previous Chiropractic Care? ☐ Yes ☐ No This year? ☐ Yes ☐ No

Were you ever put on a Spinal correction program? ☐ Yes ☐ No

If yes, who was the Chiropractor you completed your Spinal correction program with? _____

Health History:

Please check all of the following health concerns you have experience, even if you do not think that your answers relate to your present health concerns:

Allergies	☐ Yes	Heart Condition	☐ Yes
Anxiety	☐ Yes	Immune System Disorder	☐ Yes
Asthma	☐ Yes	Infertility	☐ Yes
Arthritis	☐ Yes	Kidney Disease	☐ Yes
Back Pain	☐ Yes	Menstrual Cramps	☐ Yes
Bladder Problems	☐ Yes	Mood Swings	☐ Yes
Cancer	☐ Yes	Neck Pain	☐ Yes
Circulatory/Vascular Problems	☐ Yes	Numbness/Tingling	☐ Yes
Depression	☐ Yes	Osteoporosis	☐ Yes
Diarrhea	☐ Yes	Sinus Trouble	☐ Yes
Digestive Problems	☐ Yes	Skin Conditions	☐ Yes
Dizziness	☐ Yes	Sugar Problems/Diabetes	☐ Yes
Headaches	☐ Yes	Urinary Difficulty	☐ Yes
Heartburn/Reflex	☐ Yes	Vertigo	☐ Yes
Heart Disease	☐ Yes	Other:_____	☐ Yes

List all previous surgeries and approximate dates: _____
_____

Have you ever had any broken bones/fractures? ☐ No ☐ Yes _____

List all medications that you currently take: ☐ Pain meds (over the counter or prescription) ☐ Birth control
☐ Cholesterol drugs ☐ Antidepressants/Anti-anxiety meds ☐ Anti-Inflammatory drugs ☐ Aspirin
☐ Muscle "relaxers" ☐ Recreational drugs ☐ Other _____

If you checked any of the above medications, please **list the name of drugs**, **how long you've been on each medication**, **dosage**, **who prescribed them** and for **what reason you are taking them**. It is important to let the doctor know in order to ensure proper interpretation of the diagnostic results of your spinal nerve scans:

_____
_____
_____
_____

Do you have any family history of: (check all that apply with mother, father, sister, brother, or grandparents)
☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Arthritis ☐ Osteoporosis ☐ Other _____

Stress History: Please indicate whether you have ever experienced stress in any of the following areas. Your answer will enable us to determine which factors have contributed to your present health concerns.

Childhood:

Repeated/Prolonged Antibiotic use	☐ Yes	Inhaler use	☐ Yes
Car accident	☐ Yes	Prescription medications	☐ Yes
☐	☐	☐	☐
Fall/Jump from < 3 feet	☐ Yes	Vaccination	☐ Yes
Fall/Jump from > 3 feet	☐ Yes	Youth sports	☐ Yes
Head trauma	☐ Yes	Other traumas (physical or emotional)	☐ Yes _____

Adulthood:

Alcohol consumption	☐ Yes	Inhaler use	☐ Yes
Repeated/Prolonged antibiotic use	☐ Yes	Prescription medications	☐ Yes
Car accident	☐ Yes	Smoker	☐ Yes
Coffee drinker	☐ Yes	Surgery	☐ Yes
Drug use/Abuse	☐ Yes	Contact sports	☐ Yes
Fall/Jump from a height	☐ Yes	Extreme sports	☐ Yes
Head trauma	☐ Yes	Workplace stress	☐ Yes
Home environment stress	☐ Yes	Other traumas (physical or emotional)	☐ Yes _____

Lifestyle Information:

Do you exercise regularly? ☐ No ☐ Yes, how much and how often? _____

Do you smoke? ☐ No ☐ Yes, if yes, how much? _____

Do you consume alcohol? ☐ No ☐ Yes, if yes, how much and how often? _____

Do you drink soft drinks (diet or regular)? ☐ No ☐ Yes, if yes, how much and how often? _____

Do you drink water? ☐ No ☐ Yes, if yes, how much per day? _____

How would you rate your nutritional habits? ☐ Great ☐ Good ☐ Fair ☐ Poor

Do you take any vitamins or nutritional supplements? ☐ No ☐ Yes, if yes, what kind? _____

How many hours of sleep do you usually get? _____

How would you rate the quality of your sleep? ☐ Great ☐ Good ☐ Fair ☐ Poor

Stress level at home (personal): ☐ Low stress ☐ Medium stress ☐ High stress

Stress level at work: ☐ Low stress ☐ Medium stress ☐ High stress

What do you do to relieve or handle your stress? _____

Which best describes your reason for consulting this office? (You may choose more than one)
☐ I have a specific concern and require help only with this
☐ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health
☐ I want to be healthier five years from now than I am today

Administrative Information:

Who is financially responsible for this account? _____

Relationship to Patient: _____

Do you have health insurance coverage? ☐Yes ☐No

Name of Insurance Co. _____ Subscriber's Name:_____

Group #: _____ Birth date of Subscriber: _____ Subscriber SS#_____

If you want your insurance company billed or wish for us to check on your chiropractic benefits, please provide your insurance card for a photocopy now.

If you intend to use Medicare benefits please let us know now.

Assignment of Benefits

I understand that I am financially responsible for all care whether or not paid by insurance. I hereby assign all chiropractic benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health / medical plan, to issue payment check(s) directly to **Gregory L. Anderson, D.C.** for chiropractic services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Gregory L. Anderson, D.C.** to: 1) release any information necessary to insurance carriers regarding my condition and care; 2) to process insurance claims generated in the course of examination or care; and 3) to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested chiropractic services from **Gregory L. Anderson, D.C.** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Date Relationship to Patient

_____ _____

Patient Signature (all information is filled out accurately to the best of my knowledge) Date

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____

Doctor of Chiropractic Name:Dr. Gregory L Anderson, D.C._____

Signature of Doctor of Chiropractic:_____

Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I understand that the Office of Gregory L. Anderson, D.C. may share my protected health information (PHI) for health care, billing and office operations. I understand that this office has the right to change this Notice at any time. I may obtain a current copy by contacting the doctor's office.

My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

_____
Print Name

_____
Signature of Patient or Legal Representative

_____
Date

****
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___Individual refused to sign

___Communications barriers prohibited obtaining the acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___Other (Please Specify)_____

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