WE CARE wellness centre
11001 Broad St. SW, Pataskala OH 43062
James L. Wion D.C.
P: (740) 927-3494
F: (740) 927-3496

Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT

Today's Date:

Name: Email Address:

Address: City: State: Zip:

Age: Birthdate: Marital Status: S ☐ M ☐ W ☐ D ☐ # of Children:

Home Phone: Cell Phone: Work Phone:

Please circle one payment type: Cash Check Mastercard/Visa Discover

Your Employer: Occupation: Years on Job:

Employer Address: City: State: Zip:

Your SS# Drivers License #

Do you have health insurance where you work? Yes ☐ No ☐ Plan/Group #

Insurance Company:

Name of Spouse or Parent: Birthdate:

Spouse Employed by: Occupation: Years on Job:

Employer Address: City: State: Zip:

Office Phone: Spouse SS# Driver License #

Does your spouse have health insurance at work? Yes ☐ No ☐ Plan/Group #

Describe the major medical complaint that brings you to our office:

Is your condition due to an accident? Yes ☐ No ☐ If yes, then date of accident:

Type of accident? Auto ☐ Work/On the Job ☐ At Home ☐ Other ☐

Have you ever been in an auto accident? Past Year ☐ Past 5 Years ☐ Over 5 Years ago ☐ Never ☐

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement bewtween an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or no covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patients Signature: **Date:**

Spouse or Guardian's Signature: **Date:**

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.
Insurance Cases: On all insurance the deductible must be met in the beginning unless prior arrangements are made

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Name _____ Date _____

Health Questionnaire

List all your current health problems

List any other doctors seen and list treatment received and results obtained

List all surgeries you have had and list dates

List any medications you are now taking:

Have you ever been in an automobile accident? Yes ☐ No ☐ When? _____

Have you ever had an industrial injury or any other injury for which you received treatment? Yes ☐ No ☐ When?

Please check the conditions you have or have had:

☐ AIDS or HIV+	☐ Epilepsy	☐ Polio
☐ Anemia	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Arthritis	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Cancer	☐ Parkinson's Disease	☐ Venereal Disease

FAMILY HISTORY	Age	Health problems or cause of death
Mother:		
Father:		
Mother's mother:		
Mother's father:		
Father's mother:		
Father's father:		
Brothers:		
Sisters:		
Children:		

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Please check all present symptoms Name _____ Date _____

CARDIOVASCULAR SYSTEM

- ☐ general swelling
- ☐ swelling in legs
- ☐ swelling in face
- ☐ swelling around eyes
- ☐ chest pain
- ☐ pounding heart beat
- ☐ heart "jumps"
- ☐ rapid heart beat
- ☐ blue or purple nail beds
- ☐ ringing in ears
- ☐ heart attack
- ☐ high blood pressure
- ☐ irregular heart beat
- ☐ hardening of the arteries
- ☐ areas of muscle weakness
- ☐ dizziness with nausea
- ☐ dizziness without nausea
- ☐ blurred vision
- ☐ fainting spells
- ☐ stroke
- ☐ diabetes
- ☐ pain over the heart
- ☐ cold hands and or feet
- ☐ arthritis of the neck
- ☐ previous neck or head injury
- ☐ loss of memory
- ☐ inability to form words (talk plainly)
- ☐ periods of blindness in one eye
- ☐ areas of abnormal sensations such as burning etc
- ☐ areas of numbness
- ☐ blood vessel disease (phlebitis etc)
- ☐ check if you smoke
- ☐ check if any of your family has had a stroke
- ☐ check if you are taking birth control pills

VERTEBROBASILAR

- ☐ double vision
- ☐ loss of coordination
- ☐ irregular muscle movement

MUSCULOSKELETAL SYSTEM

HEAD

- ☐ unusually frequent headaches
- ☐ unusually severe headaches
- ☐ head feels heavy
- ☐ vertigo
- ☐ light headedness
- ☐ loss of smell
- ☐ loss of taste
- ☐ loss of balance
- ☐ dizziness

NECK

- ☐ pain in neck
- ☐ neck pain with movement
- ☐ stiff neck
- ☐ pinched nerve in neck
- ☐ neck feels out of place
- ☐ muscle spasms in neck
- ☐ grinding sound in neck
- ☐ popping sound in neck
- ☐ limited neck movement

SHOULDERS

- ☐ pain in shoulders (R L)
- ☐ pain across shoulders
- ☐ muscle spasms in shoulder
- ☐ can't raise arm
  - ☐ above shoulder level
  - ☐ over head

ARMS AND HANDS

- ☐ pain in upper arm
- ☐ pain in forearm
- ☐ pain in hands
- ☐ pain in fingers

sensation of pins & needles

- ☐ in arms
- ☐ in fingers

- ☐ fingers go to sleep
- ☐ hands cold
- ☐ swollen joints in fingers
- ☐ sore joints in fingers
- ☐ loss of grip strength

MID BACK

- ☐ mid back pain
- ☐ pain between shoulder blades
- ☐ sharp stabbing pain
- ☐ dull ache
- ☐ pain from front to back
- ☐ pain over kidney area
- ☐ muscle spasms in mid back

LOW BACK

- ☐ low back pain
- ☐ low back feels out of place
- ☐ muscle spasms in low background

HIPS, LEGS, & FEET

- ☐ pain in buttocks
- ☐ pain down leg
- ☐ knee pain
- ☐ leg cramps
- ☐ pins & needles in legs
- ☐ numbness in leg
- ☐ numbness in toes
- ☐ cold feet
- ☐ swollen ankles
- ☐ swollen feet

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Please check all present symptoms Name _____ Date _____

SKIN HAIR NAILS
- ☐ eczema
- ☐ itchy skin
- ☐ dry scalp
- ☐ oily scalp
- ☐ rough, scaly skin
- ☐ dry skin
- ☐ oily skin
- ☐ psoriasis
- ☐ yellow skin
- ☐ bruises easily
- ☐ paper thin nails
- ☐ nail biting
- ☐ baldness

EYES
- ☐ blurring of vision
- ☐ double vision
- ☐ eyes fatigue easily
- ☐ excessive tearing
- ☐ lack of tearing
- ☐ light bothers eyes
- ☐ excessive itching
- ☐ pain in eyeball

EARS
- ☐ loss of hearing
- ☐ pain in ears
- ☐ discharge from ears
- ☐ vertigo
- ☐ ringing in ears

NOSE/ SINUSES
- ☐ unusual nasal discharge
- ☐ nose bleeds
- ☐ pressure over eyes
- ☐ pressure under eyes
- ☐ obstruction of nose
- ☐ frequent colds
- ☐ sinusitis
- ☐ nasal allergies
- ☐ loss of sense of smell
- ☐ any trauma to nose

MOUTH & THROAT
- ☐ pain in mouth
- ☐ cavities
- ☐ dentures
- ☐ difficulty swallowing
- ☐ changes in voice

RESPIRATORY
- ☐ shortness of breath
- ☐ can't breathe while lying down
- ☐ dry cough
- ☐ productive cough
- ☐ coughing up blood
- ☐ wheezing

GASTROINTESTINAL
- ☐ poor appetite
- ☐ constant nibbling
- ☐ difficulty in swallowing
- ☐ indigestion
- ☐ can't eat some foods
- ☐ nausea & vomiting
- ☐ jaundice
- ☐ abdominal pain
- ☐ change in bowel habits
- ☐ diarrhea
- ☐ constipation
- ☐ hemorrhoids

GENITOURINARY

urination is ☐ frequent ☐ normal ☐ infrequent

the amount is ☐ high ☐ normal ☐ low
- ☐ need to get up at night and urinate
- ☐ abnormal intense urge to urinate
- ☐ difficulty starting to urinate
- ☐ decreased output
- ☐ pain on urination
- ☐ dribbling
- ☐ blood in urine
- ☐ cloudy urine
- ☐ lack of bladder control
- ☐ abdominal pain
- ☐ pain in throat
- ☐ bleeding gums
- ☐ abscessed teeth

SOCIAL HISTORY
- ☐ smoking
- ☐ other tobacco use
- ☐ alcohol use
- ☐ drink coffee or tea

diet is ☐ balanced ☐ unbalanced

rest is ☐ sufficient ☐ insufficient

recreation is ☐ sufficient ☐ insufficient

my family stress is ☐ severe ☐ moderate ☐ minimal ☐ none

how do you like your work?
- ☐ I like it very much
- ☐ its ok
- ☐ I hate it

my job stress is ☐ severe ☐ moderate ☐ minimal ☐ none
- ☐ nervousness
- ☐ irratibility
- ☐ fatigue
- ☐ depression
- ☐ generally feel run down
- ☐ crave sweets
- ☐ crave salt

VENEREAL DISEASE
- ☐ AIDS
- ☐ syphilis
- ☐ gonorrhea
- ☐ other

WOMEN ONLY
- ☐ painful period
- ☐ spotting
- ☐ vaginal discharge
- ☐ prementrual symptoms
- ☐ irregular periods
- ☐ lumps in breasts

# of pregnancies _____

# of deliveries _____

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Accidental Injury Report

Name: Today's Date:

Date of Accident: Time of Accident: Location of Accident:

Type of Accident: ☐Auto/ Traffic ☐Work/ On the Job ☐At Home ☐Other

describe how the accident occurred in your own words

Immediately following the accident how did you feel?

How did you feel the next day?

Were you unconscious? ☐Yes ☐No In a daze? ☐Yes ☐No Did you go to the hospital? ☐Yes ☐No

If you went to the hospital, when? ☐At time of accident ☐Next day ☐Other

How did you get to the hospital? ☐Ambulance ☐Private Transportation

Did the ambulance attendants place you in ☐Neck collar ☐Splints ☐Brace ☐None of the above

Name of the hospital attended by Dr.

Were you x-rayed at the hospital? ☐Yes ☐No If so, what was the diagnosis?

How long did you stay? What treatments were rendered?

What recommendations were made?

List any other doctors you have seen as a result of this accident and what you saw them for

Have you lost any time from work because of this accident? ☐Yes ☐No If yes, give the dates

Totally disabled from to Partially disabled from to

Have you returned to work since the accident? ☐Yes ☐No Please complete the below

Date Employer Occupation Light duty/ Reg. Duty Full time/ Part time

Since the accident occurred, are your symptoms ☐Improving ☐Getting Worse ☐No Change

Do you notice any activity restrictions as a result of this injury? ☐Yes ☐No Please describe:

Have you been contacted by an insurance adjuster or company representative about this accident? ☐Yes ☐No

If so, please list name and phone # of the person contacting you:

Have you retained an attorney? ☐Yes ☐No Date attorney retained or to be retained:

Attorney's name: Phone number:

Address:

Were there any witnesses? ☐Yes ☐No Names:

Other patient information

Patient's Signature: Date:

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Accidental Injury Report

Name: _____ Today's Date: _____

WORK/ ON JOB ACCIDENT

List any equipment, machinery, and/or other object related to the accident? _____

Was accident reported to a supervisor or employee? ☐Yes ☐No If so, whom? _____

Has a Worker's Compensation claim been filed? ☐Yes ☐No Insurance Carrier _____

Name of your immediate supervisor/ foreman: _____ Office phone # _____

Type of work being done at time of injury? _____

Length of time you have worked there prior to the accident? _____ Have you been injured before? ☐Yes ☐No

Job title / Activity: _____

In a typical 8 hour workday I (tick the # of hours for each activity)

Sit: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 Stand: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 Walk ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

On the job I perform:	Not at all	Occasionally	Frequently	Continuously
Bend/ Stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above head	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Push/ Pull	☐	☐	☐	☐
I LIFT UP TO:				
10 pounds	☐	☐	☐	☐
25 pounds	☐	☐	☐	☐
50 pounds	☐	☐	☐	☐

Patient's Signature: _____ Date: _____

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