Well Being
Health Center

OFFICE USE ONLY
DATE: _____
TYPE: _____
Gender: _____

Your Personal Information

Name: _____ Preferred Name: _____ Referred By: _____
Physical Address: _____ City: _____ State: _____ Zip: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Ph: _____ Work Ph: _____ Cell Ph: _____
Marital Status: _____ No. of Children: _____ SSN: _____
Date of Birth: _____ Occupation: _____
Employer Name, Address, Phone: _____
_____ Employment Status: _____
Email Address (to be included in our newsletter & upcoming events): _____
Name of person(s) financially responsible for your care: _____ ☐ Financial Policy Signed
Relationship: _____ DOB: _____ Phone: _____
Insurance that may pay for your care: _____ ID# _____

Your Current Condition

When was your last chiropractic adjustment? _____
What is the primary reason for today's visit: _____
How long have you had this condition? _____ Was the onset Gradual or Sudden: _____
When it is at its worst, what does the pain feel like? _____
Which activities does it interfere with the most? (sleep, work, etc) _____
Have you seen any other doctors for this condition: _____
What have you done to attempt to alleviate the condition: _____

Please check the symptoms that apply: **(O)** Occasionally **(F)** Frequently

(O)	(F)	
___	___	Headaches
___	___	Dizziness
___	___	Insomnia
___	___	Upper Neck Pain
___	___	Poor Concentration or Memory
___	___	Hyperactivity
___	___	Ringing in Ears
___	___	Facial Pain/Numbness
___	___	Pain /Numbness in Fingers
___	___	Swollen Throat Glands
___	___	Shakiness in Hands
___	___	Lower Neck Pain
___	___	Trouble Staying Warm
___	___	Pain /Numbness Hands or Arms
___	___	Arms Feel Heavy
___	___	Chest Pains / Tightness
___	___	Out of Breath Easily
___	___	Asthma
___	___	Bronchitis
___	___	Pneumonia
___	___	Upper Back Pain
___	___	Pain Between Ribs
___	___	Heartburn
___	___	Gas

(O)	(F)	
___	___	Indigestion
___	___	Poor Energy
___	___	Stiffness in Joints
___	___	Allergies
___	___	Swollen Ankles
___	___	High Blood Pressure
___	___	Depression
___	___	Diarrhea
___	___	Frequent Urination
___	___	Low Back Pain
___	___	Pain in Hips
___	___	Leg Pain / Numbness
___	___	Cramps in Legs
___	___	Painful Urination

Women Only

___	___	Irregular Heavy Period
___	___	Bladder Leakage
___	___	Cramps
___	___	PMS
___	___	Breast Tenderness
___	___	Hot Flashes
___	___	Miscarriage
___	___	Can't get Pregnant

Please check any that apply:

- ☐ Cancer
- ☐ Heart Disease
- ☐ Rheumatoid Arthritis
- ☐ Sexually Transmitted Disease
- ☐ AIDS
- ☐ Migraine Headaches
- ☐ Carpal Tunnel Syndrome
- ☐ Thyroid Trouble
- ☐ Hiatal Hernia
- ☐ Colitis
- ☐ Osteoporosis
- ☐ Gall Bladder Trouble
- ☐ Alcoholism
- ☐ Diabetes
- ☐ Epilepsy

Many problems in our bodies start out as short-circuits in our nervous system. Since almost all of these points of nerve distress are found in the spine, it is very important for us to know which accidents may have misaligned your vertebrae from their normal positions. Think hard!

Please describe the accident and what year (approximately) it took place:

Most recent auto accident(s): _____

Low back injury from lifting, bending or twisting: _____

Sports related injuries: _____

Slipped on ice, ladder or stairway: _____

Repetitive injuries to wrist or neck (keyboarding, looking down for hours): _____

_____

Any other issues you would like the Doctor to know about: _____

_____

The results you are hoping to achieve through Chiropractic care:

Relieve immediate discomfort _____ Condition improved to hold for a few months _____

Spine and nervous system improved and maintained regularly _____

Surgeries

- o Tonsils
- o Tubes in ears
- o Thyroid
- o Breast
- o Hysterectomy
- o Hemorrhoids
- o Prostate
- o Hernia
- o Other _____

Medications (current or past 10 years)

- o Birth Control
- o Sleeping Pills / Tranquilizers
- o High Blood Pressure
- o Corticosteroids
- o Painkillers (Tylenol, Advil, Aspirin, etc)
- o Other _____

Check if applies:

- o Chewing Tobacco
- o Cigarettes
  Per day _____
- o Alcohol
  Per day _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Well Being Health Center will assist me in preparing any necessary reports and documentation to assist me in making collection from the insurance company. Any amount authorized to be paid directly to the WBHC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be due and payable within 15 days.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic and Wellness care, and I give authority for these procedures to be performed. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient affirms that all information given is true and accurate to the best of his/her knowledge.

_____ _____

Patient/Guardian Signature Date

Office Use

Cervical	***Thoracic***	***Lumbar***	***Other***
723.1 Cervicalgia	724.1 Thor Pain	724.2 Lumbalgia	724.3 Siatica
739.1 Cerv Sub	739.2 Thor Sub	739.3 LS Sub	739.4 SI Sub
839.08 Mult Cerv Sub	847.1 Thor S/S	724.4 LS N/R	784.0 Headache
847.0 Cerv S/S		847.2 Lumbar S/S	719.45 Hip Pain
			719.41 Shoulder Pain

Well Being
Health Center

Dr. Michelle Cho Gip
19337 Jensen Way NE · Poulsbo, WA 98370
Tel: (360) 697-6100 · FAX: (360) 697-4500
www.WellBeing-Center.com

Terms of Acceptance

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting a lessening the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if with during the course of a Chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept Chiropractic care on this basis.

_____ _____

Signature Date

WELL BEING HEALTH CENTER/WELL BEING YOGA LLC
19045 State Highway 305 Ste. 190
Poulsbo, WA98370
360-697-6100

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Well Being Health Center/Well Being Yoga LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Certain treatments may be performed in a common therapy area and/or you may find yourself within public areas within the clinic times; please note, private rooms are always available, upon request, for discussing your private health information.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date