OKLAHOMA HEALTH & WELLNESS CENTER

The doctor and staff of Oklahoma Health and Wellness welcome you and want to provide you with the best possible care.

**Please Print Clearly**

## Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Name you would like to be called:_____ Sex: M F

Marital Status: Single Married Widowed Divorced Name of Spouse: _____

Address: _____ City, State, Zip:_____

SOCIAL SECURITY NUMBER: (MUST BE FILLED OUT) _____-_____-_____ Race:_____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Email Address:_____

**Would you like to receive appointment reminders? Please select one or both.**

Email Text Message

In an effort to reduce paper waste, we would like to offer another option for receiving statements. Please select only one.

I would like to receive my statements by: Email Mail

## Guarantors Information

Policy Holders Name_____ DOB_____ SS#_____-_____-_____

Policy Holders Employer _____

## Employment Status

Employment Status: Employed Unemployed Retired Part-time Student Full-time Student Other

Employer: _____Occupation:_____

## How Were You Referred to Our Office?

By a Patient By a Doctor Newspaper Website Yellow Pages Other

Please Print the Name of Your Source_____

## Is your illness or injury related to any of the following?

Employment Emergency Accident Auto Accident (state of auto Accident) _____Claim #_____

If Employment related, has employer been notified? Yes No

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Chart Number_____

**List your health concerns in order of importance**:

| Health Concern | What have you tried to solve this concern? |
|---|---|
| 1. | |
| 2. | |
| 3. | |

Have you ever been to a Chiropractor? ____ If yes, How Long ago_____
If yes, what type of care did you receive? (Relief / Correction / Wellness)

**How do you regularly care for your health?** ***(Circle All which apply)***

A. Vitamins/Minerals B. Holistic Care C. Exercise
D. Regular Medical E. Good diet/nutrition F. Chiropractic
G. Medication H. Wait for Crisis I. Other_____

**What have been the results of those choices?**

A. Great results B. Some Results C. No Change
D. Worse E. Still Trying F. Other _____

**This health condition is beginning to affect my….? (Or will affect)**

A. Job B. Marriage C. Time
D. Kids E. Self esteem F. Finances
G. Future abilities H. Sleep I. Not Applicable

**On a scale of 1 to 10, how committed to getting well are you?**

*(1 No interest – 10 Total Commitment)* 1 2 3 4 5 6 7 8 9 10

***Current List of Surgeries, Medications, and History of Trauma***

- **List all operations and their date:**
  1. 2.
  3. 4.
- **Medications currently taking: (if more than two please provide list)**
  1. 2.
- **List any significant PHYSICAL traumas from birth to the present:**
  1. 2.

# HISTORY CHECKLIST

## SOCIAL HISTORY

Smoking History: Yes_____ Never_____ Former_____

Alcohol History: Casual_____ Moderate_____ Heavy_____

Exercise History: Never_____ Daily_____ Weekly_____

## FAMILY HISTORY

Check any that apply to your family (Past or Present)

_____High Blood Pressure _____Asthma _____Ulcer or Stomach Problems _____Thyroid Disease

_____Heart Attack _____Diabetes _____Stroke _____Circulation Problems

_____Emphysema _____Kidney Disease _____Arthritis-Rheumatism _____Cancer

_____Seizures/Convulsions _____Pacemaker _____Mental Illness _____Osteoporosis

_____HIV Postive

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, whether or not my insurance company contributes. I hereby authorize the doctors at The Oklahoma Health and Wellness Center and whomever they may designate as their assistance to administer care as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or care. I certify that the information in this entire intake form is true and correct. By signing below I also acknowledge receipt of the privacy practice of this office.

By signing this we hereby give you or your representative permission to use any/all telephone numbers by personal or pre recorded/artificial voice message and/or use of an automatic telephone device. We may also contact you by e-mail or text messaging.

Patient's (Parent or Guardian's) Signature_____ Date:_____

**If you have insurance please provide your ID Card when you return this form to the receptionist. As a courtesy we will file your insurance for you.**

**We Look Forward To Serving You!**