wellness lounge

Chiropractic • Massage • Acupuncture
Nutrition • Yoga Treatment

Welcome,

We would like to take a moment to welcome you to the wellness lounge. Whether you are here for a one-time visit, or are looking for a long-term comprehensive health solution, we look forward to our role in your care. Attached are questions that assist our staff in understanding “where you are coming from” and how we can best serve you.

The Wellness Lounge strives to encompass all aspects of your being to bring whole health to your mind, body, and spirit. One’s optimum health potential will be reached when balance exists between these three components. Pain and disease are often symptoms, which are a result from imbalance in our lives. This form will aid us in discovering where your imbalance and symptoms are so we can work together to resolve them.

Our goal is to provide you with an atmosphere that is both relaxing and comfortable. A place you may receive the healing benefits of massage and chiropractic.

Thank you for taking this opportunity to care for yourself. We cannot give what we do not have so your investment in yourself is a blessing to your friends and family.

In health and happiness,

The Wellness Lounge Staff

THE WELLNESS LOUNGE

Client Information:

Name: _____
LAST FIRST MIDDLE

Address: _____
STREET CITY STATE ZIP CODE

Date of Birth:_____ Age:_____ Astrological Sign:_____

Gender: _____ Marital Status_____ Preferred Language Spoken _____

Occupation:_____ Employer:_____
Hours worked per week?:_____ Social Security #:_____ - _____- _____
(For Insurance Patients Only)

Contact Information:

Cell Phone #:(___)____-_____ Work Phone #:(___)____-_____
Home Phone #:(___)____-_____

Would you like to receive appointment confirmations and reminders via text message?
_____

Email Address:_____

Emergency Contact:_____ Home Phone #:(___)____-_____
NAME & RELATION

HOW DID YOU FIND US?_____

DO YOU CURRENTLY RECEIVE ANY OF THESE COMPLEMENTING HEALTHCARE PRACTICES?

☐ACUPUNCTURE	☐HOMEOPATHY	☐CHIROPRACTIC
☐NATUROPATHY	☐POLARITY THERAPY	☐PSYCHOTHERAPY
☐REFLEXOLOGY	☐REIKI	☐YOGA

Other:_____

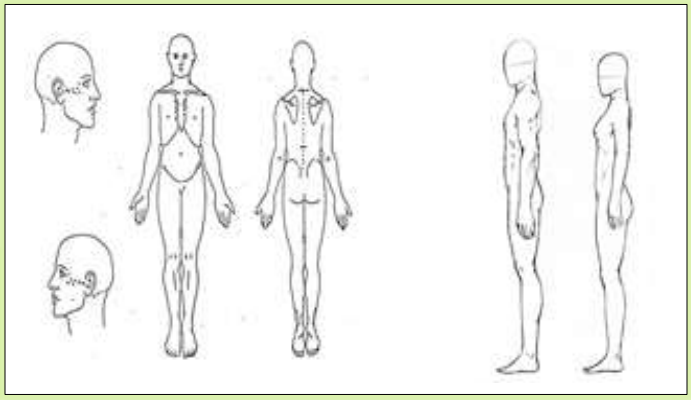
Which of the following Professional Wellness Lounge Healers are you *initially* seeking?

☐ Chiropractic ☐ Acupuncture ☐ Nutritional
☐ Massage Therapy

ARE YOU INTERESTED IN ANY **ADDITIONAL** SERVICES AT THE WELLNESS LOUNGE?

☐ACUPUNCTURE	☐CHIROPRACTIC	☐CHIROPRASSAGE
☐MASSAGE THERAPY	☐NUTRITIONAL CONSULT	☐PPREGNANCY MASSAGE
☐ACUSSAGE	☐YOGA TREATMENT	☐COUPLE'S MASSAGE

Please Circle Your
Problematic Areas
On The Diagram To
The **RIGHT.**
➔



What is your primary reason for seeking care at our office today?_____
_____
When did this problem begin?_____
_____

Rate Your PAIN LEVEL on a Scale of 1-10:

1 2 3 4 5 6 7 8 9 10

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____

CHIROPRACTIC HISTORY:

- Have you received chiropractic treatment in the past? ☐YES ☐NO
  If Yes, what was the date of your last visit/treatment:_____/_____/_____
  - Do you perform any repetitive movement in your work, school, sports, or hobbies causing pain or discomfort? ☐YES ☐NO
  EXPLAIN:_____

MASSAGE THERAPY HISTORY:

- Have you received a professional massage in the past? ☐YES ☐NO
- If Yes, what was the date of your last visit/treatment:_____/_____/_____
- Do you have difficulty lying on your back or stomach? ☐YES ☐NO
- Do you have allergies to nuts, oils, lotions, or ointments? ☐YES ☐NO
  EXPLAIN ALLERGIES:_____

ACUPUNCTURE HISTORY:

- Have you received a professional acupuncture in the past? ☐YES ☐NO
- If Yes, what was the date of your last visit/treatment:_____/_____/_____
- Do you have difficulty lying on your back or stomach? ☐YES ☐NO
- Do you have allergies? EXAMPLES: oils, lotions, ointments, medications, or herbs? ☐YES ☐NO
  EXPLAIN ALLERGIES:_____

Are you currently taking any medications? ☐YES ☐NO
Are you currently taking any supplements and/or regular vitamins? ☐YES ☐NO

- *If yes, please list name[s] and reason[s] for medications/supplements/vitamins*:_____
  _____

Please list ANY past OR future surgery procedures, with the corresponding surgery dates:_____
_____
Please list any pertinent family medical history :_____
_____
Do you experience stress in your work, family, or any other aspect of life? ☐YES ☐NO

- How do you think it has affected your health? ☐MUSCLE TENSION ☐ANXIETY ☐INSOMNIA ☐IRRITABILITY ☐OTHER:_____

Complete Health history:

Please review this list and check those conditions that have affected your health:

Either recently OR in the past, please place a check mark next to the condition

Musculoskeletal:

- ☐ Bone or Joint Disease
- ☐ Tendonitis / Bursitis
- ☐ Arthritis / Gout
- ☐ Jaw Pain (TMJ)
- ☐ Lupus
- ☐ Spinal Problems
  Explain:_____
- ☐ Other:_____
  _____

Digestive:

- ☐ Irritable bowel syndrome
- ☐ Ulcers
  - ☐ Bleeding
  - ☐ Non-Perforated
- ☐ Other:

_____
_____

Skin:

- ☐ Allergies:_____
  _____
- ☐ Rashes
- ☐ Athletes Foot
- ☐ Herpes / Cold Sores
- ☐ Other:_____
  _____

Nervous System:

- ☐ Shingles
- ☐ Numbness
- ☐ Tingling
- ☐ Pinched Nerve
- ☐ Loss of use in any extremity
- ☐ Other:_____
  _____

Circulatory:

- ☐ Heart Condition:_____
- ☐Phlebitis / Varicose Veins
- ☐ Blood Clots
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Lymphedema
- ☐ Thrombosis / Embolism
- ☐ AIDS / HIV
- ☐ Other: _____

Respiratory:

- ☐ Breathing Difficulty / Asthma
- ☐ Emphysema
- ☐ Sinus Problems:
- ☐ Respiratory Allergies: _____
- ☐ Other:_____
  _____

Reproductive:

- ☐ Pregnant

Stage (If Currently Pregnant):____Months.

- ☐Ovarian / Menstrual Problems
- ☐ Prostate Problems
- ☐ Other: _____
  _____

Other:

- ☐ Cancer
- ☐ Tumors
- ☐ Bladder / kidney ailment
- ☐ Diabetes
- ☐ Chronic Drug Use
- ☐ Alcoholism / Chronic Alcohol use
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Sleep Disorder:_____
  - ☐*Medication:*_____
- ☐ Migraines / Headaches
- ☐ Anxiety / Stress Syndrome / P.T.S.D.
  - ☐*Medication:*_____
- ☐ Depression
  - ☐*Medication:*_____
- ☐ Contact Lenses / Glasses

I have completed the above health history to the best of my knowledge and will inform my health practitioner of any change in my physical or mental health.

(Sign Name):_____
(Print Name):_____

NOTE TO PATIENT:

When a patient seeks chiropractic, massage, or acupuncture health care, and we accept that patient for such care, it is ESSENTIAL for BOTH patient and practitioner, to be working toward the SAME health objective.
The ultimate goal of the chiropractic treatment is to remove subluxations in the spine that interfere with the expression of the body's innate intelligence. The intent of massage therapy is to decrease muscle tension and increase blood flow to the affected area, while promoting relaxation. It is important that the patient understands the method by which the body is healed through chiropractic, massage therapy, or acupuncture, in order to prevent any confusion or disappointment.

CHIROPRACTIC ADJUSTMENT:

An Adjustment is the specific application of force to facilitate the correction of subluxation. Our chiropractic method of correction is through specific, and various, adjustments of the spine. Vertebral Subluxation: A misalignment of one or more of the twenty four vertebra in the spinal column. This leads to the alteration of the nerve function, which interferes with the transmission of mental impulses, ultimately lessening the body's innate ability to express its full health potential.

MASSAGE THERAPY:

One of the most appreciated results from therapeutic massage is the relief from chronic pain. For people with chronic pain, inability to work due to disabilities caused by accidents, repetitive use, or a life time of undesirable posture, massage therapy can help to alleviate experienced problems, or be used as a preventative measure. While no one modality of treatment can guarantee 100% success, more people than not can recover from constricted movement and pain patterns. Occasionally, one treatment will resolve a problem. Usually, several treatments will bring about extended benefit, with the intent of permanent resolution.

ACUPUNCTURE:

Your initial acupuncture session starts as a health and wellness assessment that emphasizes health history and current symptoms. At that time we look at health goals and physical, mental, and emotional assessment. Your initial session includes a consultation of nutrition and exercise. Next we determine any imbalances in pulse, tongue and physical symptoms.

CONSENT TO INITIATE CARE

I understand that a chiropractor, massage therapist, acupuncturist, and/or nutritionist, cannot diagnose any illness, emotional/mental disorder, or disease, and I am responsible for consulting the medical doctor, or primary care physician for the purpose of diagnosing any additional physical/mental ailments that I may have. 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.

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.

We may disclose your public health information to another Wellness Lounge healthcare provider, transport company, community agency, family member or other third party to provide and/or coordinate health care services and treatments.

I clearly understand AND agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment of those services, unless otherwise arranged through a secondary source. IE: Insurance Coverage

I understand that if I arrive late, my session will end at the originally scheduled time, so that the client following me is not penalized.

PATIENT NAME:_____

SIGNATURE:_____ DATE:___/___/___

THE WELLNESS LOUNGE

PLEASE NOTE:
We Do Not Diagnose Any Disease or Condition Other Than Vertebral Subluxation.

CANCELLATION/ NO SHOW POLICY

Your appointment time is reserved *especially* for you. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment you may be preventing another patient from getting much needed treatment. Please call (858) 245-6049 at least 24 hours prior to your scheduled appointment if you will be unable to keep your appointment. This allows the therapists to offer that time to another patient.

If an appointment is not cancelled with at least 24 hours in advance you will be charged for the full amount of the service; this will not be covered by your insurance company.

I agree to give a 24-hour cancelation notice for any scheduled session, and I am aware that I will be charged the full fee for any late cancelations or missed appointments.

PATIENT NAME:_____

SIGNATURE:_____ DATE:___/___/___

Please Provide Your Credit Card/Debit Card Information Below In Case of No Show :

CARDHOLDER NAME: _____

CREDIT CARD #: _____

EXP: ___/____ SEC. CODE: _____ ZIP CODE: _____