WELCOME TO WHOLE HEALTH CENTER
CONTACT INFORMATION

First Name: ____________________ Last Name: ______________________

Nickname: ____________________ Gender: Male ______ Female ______

Address: ____

City: ________________________ State: ____________ Zip: ____________

Telephone – Preferred: ____________________ (circle: Home Cell Work)

Other: Home _____________________ Cell: ________________________

Work: _______________________ Date of Birth: _____________________

Do we have your permission to send appointment reminders, health newsletters, and occasional promotions to your email address? Yes ______ No ______
We will not sell or give your email to any other agency.

Email Address: ____

Emergency Contact:

Name: ___________________________ Telephone: __________________

Relationship: ________________________________

If you have health insurance, we will be happy to verify your benefits. If you have a discount plan through your insurance, please tell the front desk.

How did you learn about us? (Please circle)
Friend or Family (name) _________________________ Internet Search Facebook Radio
Physician (name) ____________________________ Our Website Signholder Newspaper
Walk-in Insurance Company _______________________ Health Fair ________________
Other __________________________

MISSION STATEMENT

Whole Health Center provides information, education, and access to complementary health services for people seeking wellness. Whole Health Center connects practitioners and neighbors to achieve optimum health. Healthy and happy people are the basis of a healthy and happy community.

DISCLAIMER

Merely an office location, through which independent practitioners conduct their business, Whole Health Center does not render any services or provide any care or treatment. The individual practitioner that performs the services is independent from Whole Health Center and is responsible for the services rendered. Additionally, not all of the practitioners at Whole Health Center are licensed medical doctors; some services available at Whole Health Center are complementary to and not a substitution for treatment by a licensed medical doctor. As such, by signing below, you indicate that you understand this disclaimer and agree to hold Whole Health Center harmless from any and all claims related to services obtained at Whole Health Center.

Signature: _________________________________ **Date**: ________________

PAIN RELIEF CENTER

Patrick Noel, D.C.

PATIENT INTAKE

Name:________________ Date of Birth:________ Age:___ M:____ F:____

Address:________________________ City:____________ Zip:________

Home Phone:__________ Cell Phone:________ Work Phone:__________

Email Address:________________ Social Security Number:____________

Marital Status:________ Children, Ages:____________ Spouse:__________

Occupation:____________ Employer:____________________

Emergency Contact Name:________________ Phone:____________

Who referred you to us?__________ How did you hear about us?____________

Referring physician:____________ Primary care physician:____________

What is your main complaint?________________________________

How long have you had this condition?________________________

Have you had similar issues in the past?______________________

Have you been treated by another healthcare provider for the current complaint?__________

If yes, who?____

Are your symptoms related to a surgical procedure?____________________

Is this condition getting better, staying the same, or getting worse?__________

When did your symptoms begin?________________________________

How did your symptoms begin?________________________________

What makes your symptoms worse?______________________________

What makes your symptoms better?______________________________

Patient/Guardian Signature:________________ **Date:**____________

Name:____________________ Date:__________

REVIEW OF SYMPTOMS Check only the ones you now have or have had in the past

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐

SKIN	NOW	PAST
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐

HEAD	NOW	PAST
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam	______	
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐

EARS	NOW	PAST
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐

NOSE	NOW	PAST
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐

MOUTH	NOW	PAST
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	NOW	PAST
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐

NECK	NOW	PAST
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐

BREASTS	NOW	PAST
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Engorgement	☐	☐

LUNGS	NOW	PAST
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐

HEART	NOW	PAST
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐

BLOOD	NOW	PAST
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐

GENITOURINARY	NOW	PAST
Urge Incontinence	☐	☐
Stress Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color	______	
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐
Contraception Type	______	
Age at First Period	______	
Duration of Cycle	______	Days
Duration of Flow	______	Days
No. of Pregnancies	______	
No. of Births	______	
No. of Abortions	______	
Menstrual Flow	Normal	Abnormal
Last Period	______	
Last Pap Smear	______	
Last Vaginal Exam	______	
Last Mammogram	______	
Last Prostate Exam	______	

Name:____________________ Date:__________

NEUROLOGIC	NOW	PAST	PSYCHIATRIC	NOW	PAST	MUSCULOSKELETAL	NOW	PAST
Seizures	☐	☐	Hyperventilation	☐	☐	Muscle Pain	☐	☐
Vertigo	☐	☐	Insecurity	☐	☐	Muscle Weakness	☐	☐
Dizziness	☐	☐	Depression	☐	☐	Muscle Cramps	☐	☐
Hand Trembling	☐	☐	Troubled Sleep	☐	☐	Muscle Twitching	☐	☐
Loss of Sensation	☐	☐	Irritable	☐	☐	Joint Stiffness	☐	☐
Discoordination	☐	☐	Undecidedness	☐	☐	Joint Pain	☐	☐
Weak Grip	☐	☐	Timid	☐	☐			
Facial Weakness	☐	☐	Hallucinations	☐	☐			
Paralysis	☐	☐	Loss of Memory	☐	☐			
Difficult Speech	☐	☐	Alcoholism	☐	☐			
Tingling	☐	☐	Drug Addiction	☐	☐			
Loss of Memory	☐	☐	Suicidal Thoughts	☐	☐			
Numbness	☐	☐	Extreme Worry	☐	☐			
			Sexual Problems	☐	☐			

ENDOCRINE	NOW	PAST
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

IMMUNIZATION	
DPT	☐
Mumps	☐
Smallpox	☐
Typhoid	☐
Tetanus	☐
Measles	☐
Pneumococcal	☐
Influenza	☐
Polio	☐
MMR	☐

BLOOD TYPE	
A+/-	☐
B+/-	☐
AB+/-	☐
O+/-	☐

PAST MEDICAL ISSUES: Check only if you have had these in the past

Hay Fever	☐	Epilepsy	☐
Mumps	☐	Paralysis	☐
Rheumatic Fever	☐	Polio	☐
Allergies	☐	Mental Illness	☐
Angina	☐	Alcoholism	☐
Cancer	☐	Depression	☐
Tumor	☐	Nervous Breakdown	☐
Blood Disease	☐	Migraine	☐
Leukemia	☐	Gout	☐
Heart Trouble	☐	Prostate Problems	☐
Varicose Veins	☐	Sexually Transmitted Disease	☐
Phlebitis	☐	Diabetes	☐
Hypertension	☐	Bladder Trouble	☐
Stroke	☐	Kidney Infections	☐
Ulcers	☐	Dysentery	☐
Jaundice	☐	Blood Transfusions	☐
Skin Trouble	☐		
Gallstones	☐	Date of Last Chest X-Ray	______
Liver Trouble	☐	Date of Last TB Test	______
Hepatitis	☐	Allergies____________	______
Parasites	☐		
Osteoporosis	☐		

SOCIAL HISTORY

Current Weight	______		Have you recently lost/gained weight?	Y/N	If Yes, how many pounds?	______
Mental Work	Heavy	Moderate	Light	Hours/Day	_____	
Physical Work	Heavy	Moderate	Light	Hours/Day	_____	
Exercise	Heavy	Moderate	Light	Hours/Wk	_____	
Smoking	Current	Previous	Packs/Day ________	Years	_____	
Alcohol	Beer	Wine	Liquor	Drinks/Wk	_____	Years __________
Caffeine	Cups/Day _____		Years ________			
Aspirin	Pills/Day _____		Years ________	Others	_______	______________

FAMILY HISTORY

Relative	Age	Death Age	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Grandparents					

OFFICE STAFF ONLY

VITALS

BP ________
HR ________
O2% ________

Initials ________

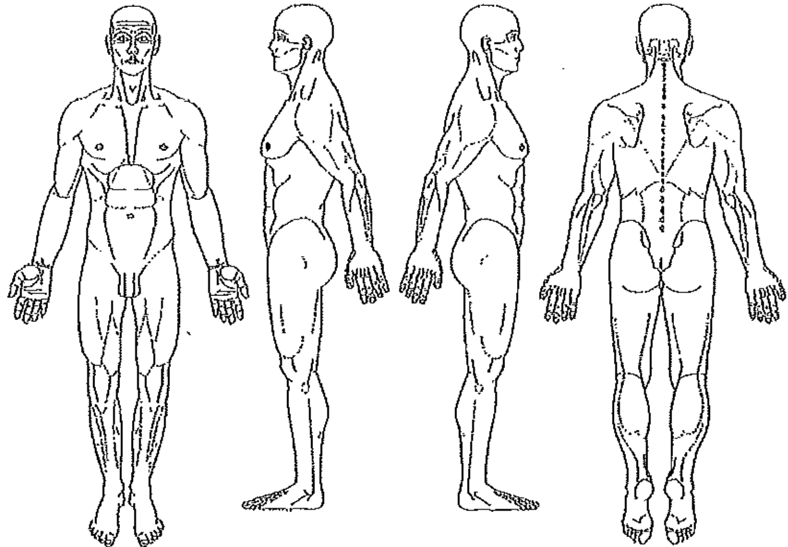
INITIAL SYMPTOMS QUESTIONNAIRE

Name ______________________________ Date ______________

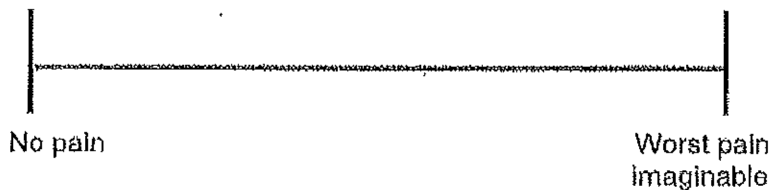
Where is your pain now?

Mark the areas on your body where you feel the sensations described below. Include all affected areas and feel free to add any additional information!

- ☐ Aching AAAA
- ☐ Shooting HHHH
- ☐ Burning BBBB
- ☐ Stabbing XXXX
- ☐ Cramps CCCC
- ☐ Stiffness FFFF
- ☐ Dull DDDD
- ☐ Swelling WWWW
- ☐ Numb NNNN
- ☐ Throbbing TTTT
- ☐ Sharp RRRR
- ☐ Tingling GGGG
- ☐ Other ______________



How severe is your pain?



(Mark a vertical line along the scale where you would describe your pain severity)

What 3 things are most difficult because of your symptoms?

1. ______________________________
2. ______________________________
3. ______________________________

Which stage of recovery is your goal for treatment?

- ☐ Relief (I want to feel better with the least amount of time/money)
- ☐ Correction (I want to stabilize my body and prevent a relapse)
- ☐ Wellness (I want to achieve my best level of health possible)

Signature ______________________________

Patrick Noel, D.C.

Policies and Informed Consent for Examination and Treatment

Cancellation Policy

Our goal is to provide you with the most advanced, effective treatments available at one-on-one appointments. As a result, we reserve space and staff time for your appointment. Except for emergency situations, anyone who does not give us 24 hours' notice of a cancellation will be charged a $30 cancellation fee.

Consent to Treat

I understand that neither chiropractic, nor shock therapy, nor Chinese meridian therapy is an exact science, and that my care may involve judgments based upon facts and information known to the providers. The provider uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but rather I wish to rely on the provider to choose and recommend a best course of treatment, based on scope of practice and facts known, that is in my best interest. I further understand that there are certain degrees of risk associated with these treatments and while rare, complications can occur including but not limited to fractures, disc injuries, strains/sprains, infection, bleeding, pneumothorax, nerve injury, and stroke. By signing below, I agree to accept and consent to the risk associated with the care that I am about to receive.

Female Patients: ☐ I am not pregnant ☐ I am or may be pregnant

PLEASE TELL US IF YOU BECOME PREGNANT

Patient/Guardian Name______________________________ Date:______________

Patient/Guardian
Signature:____

PRIVACY PRACTICES

Healthcare providers are required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use your personal health information primarily for treatment of your injury; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

We may also use and disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law, such as in cases of suspected abuse or neglect, law enforcement or national security issues, or for coroners, funeral directors, or medical examiners.

In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information, you may revoke that authorization to stop future disclosures at any time.

We may change our policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. We will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Whole Health Center may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the individual(s) listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices of if you have a complaint, please contact the following person(s):

Patrick Noel, D.C., WHOLE HEALTH CENTER

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received the above Notice of Privacy Practice at Whole Health Center.

Patient Name:________________________________ **Date of Birth:**__________________

Patient Signature:_____________________________ **Date:**__________________________

SHOCKWAVE THERAPY and/or CHINESE MERIDIAN THERAPY

Name: ______________________________ DOB: ____________ Occupation: __________________
Have you ever experienced Shockwave Therapy or Chinese Meridian Therapy? (if yes, please circle)
What are the symptoms/conditions you would like us to address? ______________________________

____

Shockwave Therapy and/or Chinese Meridian Therapy are effective in reducing stress, alleviating pain, relieving muscle tension, and increasing circulation.

Please check if you have any of the following conditions:

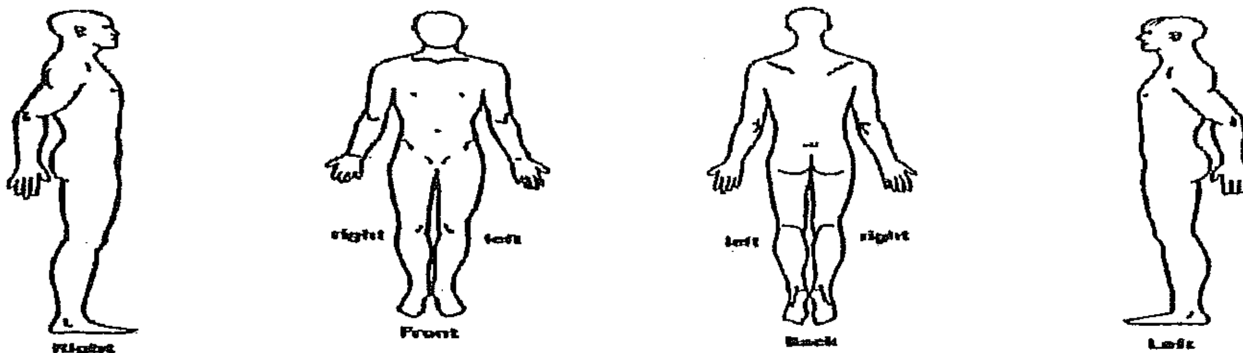
- ☐ Any organ issues or disease
- ☐ Cancer or tumor
- ☐ Infectious disease
- ☐ Hemorrhagic disease or conditions
- ☐ Pregnancy
- ☐ Active menstruation
- ☐ Any implanted silicone
- ☐ Any metal implants or stints
- ☐ Nervous or psychotic conditions
- ☐ Implantable devices, i.e. pacemaker, defibrillator
- ☐ Varicose veins
- ☐ Cognitive or mental disabilities
- ☐ Epilepsy or any condition with seizures
- ☐ Uncontrolled High blood pressure
- ☐ Cardio-vascular conditions
- ☐ Prosthetics

Please list any other current conditions:

____

Surgeries: ____
Medications: ____
Allergies/Sensitivities: ____

Please mark any areas of pain:



I understand it is my responsibility to report to Whole Health Center at each visit any changes, especially regarding the above list of conditions. I understand that complications may result from my treatment. Among these possible complications are temporary discomfort, skin redness, and aggravation of present symptoms.

I understand that given the strict adherence to Shockwave Therapy and Chinese Meridian Therapy being non-sexual services, I may undress to my level of comfort. I will discuss any questions or concerns with my pain therapist.

I understand that Shockwave Therapy and Chinese Meridian Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician or other qualified specialist for any suspected ailments. I understand that nothing said during the course of a session should be construed as diagnosis or prescription. Because Shockwave Therapy and Chinese Meridian Therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.

I agree to keep the practitioner updated as to any changes and understand that there shall be no liability on the practitioner's part should I forget to do so. I agree to hold Whole Health Center harmless from any and all claims related to Shockwave Therapy and Chinese Meridian Therapy services.

Please give 24 hours' notice to cancel an appointment. A $30 cancellation fee may be applied.

By signing below, I acknowledge that I fully understand and agree to the above information.

Signature: ______________________________________ Date: ____________________________

If patient is under age 18, parent's signature above gives permission for the patient to receive treatment.
Parent is invited to attend.