193 West Beau Street
Washington, PA 15301
Phone: 724-222-8322
Fax: 724-222-8940
www.wanowellness.com

WANO CHIROPRACTIC

Rehabilitation • Weight Loss • Fitness Center

Dr. Tony Wano, DC, FACACN, CCSP
Certified Chiropractic Sports Practitioner
Certified Clinical Nutritionist

REGISTRATION OF INFORMATION

Date: _____

PLEASE PRINT

(Please check one): ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____

First Name: _____ MI: ____ Last Name: _____ Social Security #: _____

Street Address: _____ City _____ State: ____ Zip: _____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Children: _____ Education Level obtained: _____ Referred to our office by: _____

Spouse's Name: _____ Spouse's Occupation: _____

Primary Care Physician (name, address & telephone): _____

Employer and Employer's Address: _____

Work Phone: (____) _____ Occupation: _____

Student Status: ☐ Full Time ☐ Part Time Name of School: _____

If you are the responsible party, mark "self" and move down to "Insurance Information".

Patient's relationship to responsible party: ☐ Self ☐ Spouse ☐ Dependent

First Name: _____ MI: ____ Last Name: _____ Social Security #: _____

Street Address: _____ City _____ State: ____ Zip: _____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer and Employer's Address: _____

Work Phone: (____) _____ Occupation: _____

INSURANCE INFORMATION

Insurance Company: _____ Insurance Company's telephone #: (____) _____

Insurance Company's Address: _____

Group or Policy Number: _____ Subscriber or I.D. #: _____

Secondary Insurance: _____ Insurance Company's telephone #: (____) _____

Insurance Company's Address: _____

Group or Policy Number: _____ Subscriber or I.D. #: _____

RELEASE AND ASSIGNMENT

1. I authorize the release of any medical information necessary to process my insurance claim(s)
2. I authorize and request payment of medical benefits directly to Wano Chiropractic Weight Loss & Nutrition Centers, Inc.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked in writing by me.
4. I agree that a photocopy of this form may be used in lieu of the original.
5. I hereby consent to any procedures or treatment for my condition as deemed necessary by the attending doctors at Wano Chiropractic Weight Loss & Nutrition Centers, Inc.

_____ ____/____/____

Signed (Patient or Representative) Date

_____

Patient's Name (Printed)

ATTENTION: Payment is to be made at the time of the visit unless prior arrangements have been made with this office. Also a 24-HOUR NOTICE is necessary to cancel an appointment, and you may be responsible for payment of a missed appointment.

193 West Beau Street
Washington, PA 15301
Phone: 724-222-8322
Fax: 724-222-8940
www.wanowellness.com

WANO CHIROPRACTIC

Rehabilitation • Weight Loss • Fitness Center

Dr. Tony Wano, DC, FACACN, CCSP
Certified Chiropractic Sports Practitioner
Certified Clinical Nutritionist

MEDICAL HISTORY

Name:	Date:

MAIN COMPLAINT: Why are you here today? Be specific with location: _____

_____

_____

1. When did it start? Date: _____
2. How did it start? Explain: _____
3. Recent work-related injury? ☐ Y ☐ N

   Recent auto accident? ☐ Y ☐ N

   Injury at home? ☐ Y ☐ N

   Injury elsewhere? ☐ Y ☐ N
4. Does it radiate to any other part of your body? ☐ Y ☐ N Where? _____
5. Did it begin ☐ gradually or ☐ suddenly? _____
6. How would you describe the intensity? (☐ mild, ☐ moderate, ☐ severe) _____
7. Describe your pain (☐ dull, ☐ sharp, ☐ burning, ☐ numbness, ☐ soreness, ☐ stiffness): Other: _____
8. Has your problem been getting ☐ worse, ☐ better, or ☐ about the same? _____
9. Does your condition ☐ come and go or is it ☐ all the time? _____
10. What makes your symptoms better? _____
11. What makes your symptoms worse? _____
12. Have you tried home remedies? ☐ Y ☐ N Details _____
13. Have you seen any doctors or have any tests been done for your condition? ☐ Y ☐ N Explain: _____

    _____

    _____
14. Have you had anything like this before? ☐ Y ☐ N What? _____
15. Have there been any other changes in any body functions? ☐ Y ☐ N Details: _____
16. Has your condition affected your daily activities in any way? ☐ Y ☐ N Explain: _____
17. Have you been unable to work as a result of your current problem? ☐ Y ☐ N Date last worked: _____
18. Do you have any other problems that you would like the doctors to evaluate? ☐ Y ☐ N

    Explain: _____

    _____
19. Have you had any testing done for this condition?

    Please Check: ☐ MRI ☐ X-Ray ☐ Lab Work ☐ CT Scan ☐ Other: _____

193 West Beau Street
Washington, PA 15301
Phone: 724-222-8322
Fax: 724-222-8940
www.wanowellness.com

WANO CHIROPRACTIC

Rehabilitation • Weight Loss • Fitness Center

Dr. Tony Wano, DC, FACACN, CCSP
Certified Chiropractic Sports Practitioner
Certified Clinical Nutritionist

PAST HISTORY

1. Have you had any of the following diseases: (Check) ☐ Measles ☐ Rubella ☐ Chickenpox ☐ Mumps ☐ Scarlet Fever ☐ Rheumatic Fever ☐ Tuberculosis ☐ HIV ☐ Hepatitis ☐ Other: _____
2. Have you been diagnosed with any other conditions? ☐ Y ☐ N Explain: _____
3. Are you under a doctor's care presently for any type of health problem? ☐ Y ☐ N
   Explain: _____
4. Have you had any broken bones? ☐ Y ☐ N Which ones? _____
5. Have you ever had any past significant auto accidents, work injuries or falls? ☐ Y ☐ N When? _____
6. Are you taking any medications? ☐ Y ☐ N Please list. _____
   _____
7. Have you ever undergone any type of surgery? ☐ Y ☐ N What and when? _____
   _____
8. Do you ☐ smoke, ☐ drink alcohol or ☐ use recreational drugs? Quantity: _____
9. Do you have any allergies? ☐ Y ☐ N Explain: _____
10. Do any diseases run in the family? ☐ Y ☐ N Explain: _____

SYSTEM REVIEW

HAVE YOU BEEN DIAGNOSED OR BEEN TOLD YOU HAVE THE FOLLOWING?

☐ Y ☐ N High blood pressure
☐ Y ☐ N Hardening of the arteries
☐ Y ☐ N Diabetes
☐ Y ☐ N Heart or blood vessel disease
☐ Y ☐ N Bone spurs on the neck (cervical spondylosis)
☐ Y ☐ N Whiplash injury
☐ Y ☐ N Have any of your relatives ever suffered a stroke?
☐ Y ☐ N Blurred vision
☐ Y ☐ N Double vision
☐ Y ☐ N Diminished or partial loss of vision in one or both eyes
☐ Y ☐ N Complete loss of vision in one or both eyes
☐ Y ☐ N Sudden collapse without loss of consciousness
☐ Y ☐ N Hearing loss in one or both ears
☐ Y ☐ N Slurred speech or other speech problems
☐ Y ☐ N Difficulty swallowing
☐ Y ☐ N Dizziness
☐ Y ☐ N Temporary lack of understanding
☐ Y ☐ N Loss of consciousness, even momentary blackouts
☐ Y ☐ N Numbnesss or loss of sensation in the face, arms, hands, fingers, or legs
☐ Y ☐ N Any other abnormal or loss of sensation in any other part of the body
☐ Y ☐ N Weakness, clumsinesss, or strength loss in the face, arms, hands, fingers, or legs
☐ Y ☐ N Ringing, buzzing, or any noise in the ears

WOMEN ONLY

Do you experience any of the following symptoms?

☐ Y ☐ N Do you take birth control pills? How long? _____
☐ Y ☐ N Menstrual pain
☐ Y ☐ N Cramping
☐ Y ☐ N Irregularity
☐ Y ☐ N Date of last period _____
☐ Y ☐ N Are you now pregnant? _____ How long? _____

MEN ONLY

Date of last prostate exam: _____
Difficulty with urination? ☐ Y ☐ N
Explain _____
Excessive urination? ☐ Y ☐ N
Explain _____

I hereby consent to any procedures or treatments for any condition as deemed necessary by the attending doctors at **Wano Chiropratic Weight Loss & Nutrition Centers, Inc.**

Patient's Signature: _____ Date: ____/____/____