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

PATIENT INFORMATION UPDATE

Date: _____

PLEASE PRINT

(Please circle one) ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

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

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

Street Address: _____ City: _____ State: ___ Zip: _____

Email Address:_____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ 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 ☐ 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.

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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. Are you taking any medications? ☐ Y ☐ N Please list _____
20. Have you had any surgeries or medical treatment for any condition since your last visit? ☐ Y ☐ N
    Explain: _____

    _____