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



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

PATIENT INFORMATION UPDATE

(Please circle one) Dr. Mr. Mrs. Mis Miss Home Phone: (Date:				
Home Phone:	PLEASE PRINT				
First Name:	(Please circle one) \square Dr. \square Mr. \square M	Irs. \square Ms. \square Miss			
Street Address: City: State: Zip:	Home Phone: ()	Cell Phone: ()	I	Email:	
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: Subscriber or I.D. #: Secondary Insurance: Insurance Company's telephone #: Insurance Company's Address: 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. 5 Signed (patient or representative) Date	First Name:	_ MI: Last Name: _		Social Security #: _	
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 Name: Spouse's Occupation Spouse's Occupation: Spouse's Occupation: Student Status: Full Time Part Time Name of School: Student Status: Full Time Part Time Name of School: Student Status: Full Time Part Time Name of School: Student Status: Status: Social Security #: Street Address: State: Zip: Sex: M F Date of Birth: Age: Marital Status: Single Married Divorced Separated Employer and Employer's Address: Occupation: Insurance Company's Address: Insurance Company's telephone #: (Street Address:		_ City:	State:	Zip:
Children:	Email Address:		_		
Spouse's Name: Spouse's Occupation Primary Care Physician (name, address & telephone): Employer and Employer's Address: Work Phone: (
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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

Na	ame: Date:				
M	AIN 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? $\square Y \square N$				
	Recent auto accident? \square Y \square N				
	Injury at home? $\square Y \square N$				
	Injury elsewhere? \square Y \square N				
4.	Does it radiate to any other part of your body? \square Y \square N Where?				
5.	5. Did it begin □ gradually or □ suddenly?				
6.	How would you describe the intensity? (\square mild, \square moderate, \square severe)				
7.	Describe your pain (\square dull, \square sharp, \square burning, \square numbness, \square soreness, \square stiffness): Other:				
8.	Has your problem been getting \square worse, \square better, or \square 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? \square Y \square N Explain:				
14.	4. Have you had anything like this before? Y N What?				
15.	Have there been any other changes in any body functions? \square Y \square N Details:				
16.	Has your condition affected your daily activities in any way? Y N Explain:				
17.	7. 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? $\ \Box\ Y\ \Box\ N$				
	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? \square Y \square N Explain:				