Strategic Wellness Patient Information

General Information – Please Print

Patient Name ____ Email Address __________________________

Address ___________________________ Home Phone__________________ Cell Phone __________________

City ________________________________ State ___________ Zip _______________

Referred By ______________________________

Age ____________ Date of Birth ______________ Occupation______________________________________

Sex: M F Married __ Single __ __ Check here to receive text reminders

Spouse's Name __________________

Insurance Information

Insurance Company Name __________________________ Policy Number ___________________________

Insured's Name __________________________________ Patient's Relationship to Insured ____________________

Insured's Date of Birth (if not Patient) ________________ Provider Customer Service Number _________________

Release and Assignment

Strategic Wellness conforms to current HIPAA guidelines. You may request a copy of our HIPAA Policy at the front desk. Please sign below to indicate you have been made aware of its availability.

Patient Signature ______________________________ ***Date*** ______________________________

I authorize release of any information necessary to process insurance claims and assign and request payment directly to my Strategic Wellness.

Patient Signature ______________________________ ***Date*** ______________________________

I understand Strategic Wellness will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my account when payment is received. However, I understand that all services rendered to me are charged to me and I am responsible for payment.

Patient Signature ______________________________ ***Date*** ______________________________

Nutritional Testing Authorization and Release

I specifically authorize David Ratliff D.C. to perform nutritional testing to develop a complete health improvement program for me which includes dietary guidelines and nutritional supplementation to assist me in improving my health. I understand nutritional testing is a safe, non-invasive and natural method of analyzing the body's physical and nutritional needs and that deficiencies or imbalance in these areas could cause or contribute to various health problems. I understand that nutritional testing is not a method of diagnosing or treating any disease including but not limited to: cancer, AIDS, infections or other medical conditions. Although you may be notified of possible adverse effects of medications, Dr. Ratliff does not and is not licensed to make recommendations about medications. Always discuss your medications with the prescribing physician.

I understand the success of my health improvement plan is highly dependent on my compliance with the recommended dietary modifications as well as my nutritional supplement schedule.

Patient Signature ______________________________ ***Date*** ______________________________

Informed Consent for Chiropractic Care

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and the function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation.** This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are eliminated and/ or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included. Our only practice objective is to eliminate the interference to the expression of the body's innate intelligence caused by vertebral subluxation.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in the office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

___________________________________ ___________________________________ _______________________

Printed Name ***Signature*** ***Date***

Consent to evaluate and treat a minor child

I, ___________________________ being the parent or legal guardian of __________________________ have read and fully understand the above informed consents and hereby grant permission for my child to receive chiropractic care and nutritional testing.

_______________________________ _______________________

Signature ***Date***

Pregnancy Release

I understand that Chiropractic is both safe and effective during pregnancy for most patients.
I have consulted my doctor regarding chiropractic care during my pregnancy and have no known conditions that would contradict chiropractic care.

____________________________ __________________________ _______________________

Due Date ***Signature*** ***Date***

I certify that to the best of my knowledge I am not pregnant.

__________________________ ____________________________ _______________________

Date of Last Menstrual Cycle ***Signature*** ***Date***

Strategic Wellness
6797 N. High St, Suite 120
Worthington, OH 43085

(614) 841-0005 – Office
(614) 841-0275 - Fax
drdavidratliff.com

Strategic Wellness Health History Questionnaire

Please circle where appropriate.

Do you have a primary care doctor? Y N Name of primary care doctor: ________________________

Is he/she doing anything to help you improve your health naturally? Y N
Please explain: ____

Do you currently have a health and wellness plan? Y N
Please explain: ____

Do you drink 50 or more ounces of clean pure water daily? Y N

Do you or someone in your household cook often? Y N

Do you currently plan your shopping trips around maximizing healthy and nutritious foods in your diet? Y N

Do you exercise regularly? Y N
Please explain: ____

Do you stretch regularly? Y N
Please explain: ____

Do you have any specific fitness or weight loss goals? Y N
Please explain: ____

Do you feel mostly happy or grateful? Y N
Is life stress weighing you down? Y N
Comments: ____

Do you have a specific plan or activity you practice to help you deal with stress? Y N
Please explain: ____

Do you get 7 or more hours of sleep most nights? Y N
Do you experience daytime fatigue or sleepiness? Y N

Do you have a bedtime ritual to help you wind down and sleep well? Y N

Do you have frequent digestive stress or irregularity? Y N
Please explain: ____

Females only: Do you have irregular cycles or abnormal pain associated with your cycles? Y N
Please explain: ____

Do you have or have had tooth or gum problems? Y N
Please explain: ____

Do you have frequent joint problems (pain or stiffness)? Y N
Please explain: ____

Do you have signs of skin, hair or nail problems? Y N
Please explain: ____

Do you feel like you are losing muscle mass quicker than you would expect? Y N
Please explain: ____

When it comes to guilty pleasures or poor lifestyle habits, what are yours?
Processed Foods: ____
Drugs/Medications: ____
Alcohol/Tobacco/Energy Drinks: ____
Soda, Fast Food, Junk Food, Coffee: ____

Do you take vitamins or workout enhancers? Y N
Please explain: ____

Have you ever had any surgeries? Y N
Please explain: ____

What are your expectations for coming into my office? ____
____

What are the alarm symptoms your body is giving you? ____
____

When and how did your alarm symptoms start? ____
____

What other treatments have you tried for these complaints: ____
____

Do you have any other health concerns? ____
____

Why do you think your body has failed to heal this on its own? ______________________________________
____

Do you have any past physical or emotional traumas your body has not recovered from? _________________
____

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