WEDDINGTON CHIROPRACTIC
WELLNESS CENTER

8832 Blakeney Professional Drive
Suite 100, Charlotte, NC 28277
www.weddingtonwellness.com
(704)-817-7618

ABOUT YOU

Today's Date: _____ File #: _____

Patient Name: _____ _____ _____
LAST FIRST MI

What do you prefer to be called? _____ ☐ Male ☐ Female

Birthdate: _____ Age: _____ SS#: _____

Mailing Address: _____ _____ _____ _____
CITY STATE ZIP CODE

Home Phone #: _____ Work Phone #: _____ EXT _____

Cell Phone #: _____ Email: _____

Referred By: _____

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

Spouse's Name: _____ Children: ☐ Yes ☐ No How Many: _____

Would you like to receive text and or email appointment reminders from our office? ☐ Yes ☐ No

If yes, please provide our office with your cell phone carrier: _____

INSURANCE INFORMATION *(for chiropractic treatments only)*

Primary Insurance:

Company Name: _____ Phone Number: _____

Address: _____ _____ _____ _____
CITY STATE ZIP CODE

Insured's ID #: _____ Group #: (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____ Date of Birth: _____

Secondary Insurance:

Company Name: _____ Phone Number: _____

Address: _____ _____ _____ _____
CITY STATE ZIP CODE

Insured's ID #: _____ Group #: (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____ Date of Birth: _____

IN CASE OF EMERGENCY

Whom should we contact? _____ Relation: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Who is your Medical Doctor? _____ Medical Doctor's Phone #: _____

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NEW PATIENT INFORMATION

Name: _____ DOB: _____ Age: _____ Date: _____

Are you Right or Left-Handed? _____ Height: _____ Weight: _____ ☐ Male ☐ Female

Language: _____ Race: _____

Do You Currently Smoke: ☐ Yes ☐ No How many per day? _____ ☐ Former ☐ Never

Occupation: _____

How did you hear about our office? _____

Main reason for today's visit: _____

Date of Recent Problem: _____

Is the problem: ☐ Worse ☐ Better ☐ Not Changed

Which services have you had before? ☐ Chiropractic ☐ Acupuncture ☐ Physical Therapy ☐ Medical ☐ Massage ☐ Naturopathy ☐ Other

Was it for the current problem? _____

If not, when and for what issue? _____

Have there been any injuries, surgeries, medications, allergies, or medical changes in the last two years?

_____

_____

Please provide the contact information of your Primary Care Physician: _____

Name: _____ Phone #: _____

Note: Upon providing your Primary Care information, you are giving WCWC permission to share treatment notes with your doctor.

DOCTOR'S NOTES

BP: _____ Insurance: _____

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SYMPTOMS QUESTIONNAIRE FOR ACUPUNCTURE

*****Please rate each symptom's severity from 1 to 5 (5 being the worst). Leave blank if not applicable.*****

Liv/GB(wood)
- ____ irritability/anger
- ____ depression/stress
- ____ headaches/migraines
- ____ visual problems
- ____ red/dry/itchy eyes
- ____ gall stones
- ____ dizziness
- ____ blurred vision
- ____ feeling of lump in throat
- ____ clenching of teeth at night
- ____ muscle cramping/twitching
- ____ tension
- ____ joints/neck/shoulder pain
- ____ poor circulation
- ____ soft/brittle nails
- ____ emotional eater
- ____ ringing in ears
- ____ eczema
- ____ shingles
- ____ herpes simplex
- ____ indecisive
- ____ fullness below ribs
- ____ shoulder/neck tension
- ____ insomnia 11pm-3am

Ht/SI (Fire)
- ____ heart palpitations
- ____ chest pain
- ____ insomnia/sleep problems
- ____ easily startled
- ____ restlessness/agitation
- ____ vivid dreams
- ____ lack of joy in life
- ____ dry scalp
- ____ skin rash
- ____ cysts/tumor
- ____ ear infection
- ____ sore throat
- ____ lymph swelling
- ____ hot palms/soles
- ____ aversion to heat
- ____ bitter taste in mouth
- ____ gum problems
- ____ nosebleeds
- ____ facial redness
- ____ Itchy/burning skin
- ____ thirst
- ____ dark blue
- ____ night sweats
- ____ excess joy

Sp/ST (Earth)
- ____ heaviness anywhere in body
- ____ fatigue/worse after eating
- ____ hard to get up in morning
- ____ edema (swelling)
- ____ muscles feel tired often
- ____ easily bruising and bleeding
- ____ bad breath
- ____ decreased/increased appetite
- ____ crave sweets
- ____ hypoglycemia
- ____ difficulty digesting oily foods
- ____ nausea/vomiting
- ____ gas/belching
- ____ insulin sensitivity
- ____ hemorrhoids
- ____ constipation
- ____ diarrhea
- ____ abdominal pain
- ____ indigestion/heartburn
- ____ over-thinking
- ____ tendency to gain weight
- ____ brain foggy
- ____ food allergy
- ____ excess worry

Lu/Li (Metal)
- ____ dry cough
- ____ cough with sputum
- ____ nasal discharge
- ____ post-nasal drip
- ____ sinus trouble
- ____ itchy/red/painful
- ____ dry mouth/throat/nose
- ____ skin rashes/hives
- ____ snoring
- ____ grief/sadness
- ____ shortness of breath
- ____ asthma/allergies
- ____ low resistance to colds/flu
- ____ sneezing
- ____ mild fever comes and goes
- ____ smokes cigarettes
- ____ bronchitis

Kid/UB (Water)
- ____ urinary problems
- ____ bladder problems
- ____ lack of bladder control
- ____ weakness/pain in lower back
- ____ decreased bone density
- ____ feel cold easily
- ____ low sex drive
- ____ excessive sexual drive
- ____ poor memory
- ____ loss of hair
- ____ hearing problems
- ____ cavities/tooth loss
- ____ craving/avoiding salty foods
- ____ fear
- ____ hot flash/night sweating
- ____ dark under eyes
- ____ weak leg/knees
- ____ rapid weight change
- ____ emotional instability
- ____ thyroid problems

OTHER
- ____ fatigue
- ____ arthritis
- ____ sciatica
- ____ nerve pain
- ____ carpal tunnel
- ____ numbness
- ____ cold hands/feet
- ____ bursitis/tendonitis

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CONSENT TO TREAT - ACUPUNCTURE

By signing below, I do hereby voluntarily consent to be treated with Acupuncture and/or substances by our certified Acupuncturist, Dr. Lisa Merritt.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, or modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but not limited to local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms.

Chinese Herbs: I understand that substances may be recommended to me to treat bodily dysfunction of diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances, but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include but are not limited to changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and contact Weddington Chiropractic Wellness Center immediately.

Acupressure: I understand that I may also be given acupressure as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Print Name: _____

Signature: _____ Date: _____