DWD/PA Date: _____

Total Wellness Solutions Health Profile

Name:_____ Date:_____/_____/_____

Age_____ Male___Female___Other___ Date of Birth_____/_____/_____

Address: _____City _____ State: ____ Zip:_____

Email: _____ Cell #: _____Home #: _____

May we include you in our weekly text4health text messages: Yes No (you can stop anytime)

Occupation: _____ Employer: _____

Single/Married/Divorced/Widowed Spouse's Name_____ Phone #_____

Number of Children:_____ Names, Ages, & Gender _____

Emergency Contact, Relation & Phone # _____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Severity on scale of 1-10	When did episode begin?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?

CIRCLE ALL CURRENT PROBLEMS YOU HAVE:

DIZZINESS	MIGRAINES	MENSTRUAL DISORDERS	LUPUS	NUMBNESS IN LEGS
HEADACHES	ANXIETY	HEART DISORDERS	FIBROMYALGIA	NUMBNESS IN FEET
VERTIGO	THROAT	STOMACH DISORDERS	CHEST PAIN	NUMBNESS IN HAND
INSOMNIA	ADHD	KIDNEY PROBLEM	HIP PAIN	LEG PAIN ARM PAIN
NAUSEA	ASTHMA	BLADDER PROBLEMS	SHOULDER PAIN	EAR INFECTIONS
TMJ	ULCERS	IRRITABLE BOWEL	LOW BACK PAIN	KNEE PAIN
EPILEPSY	LIVER DISEASE	INFERTILITY	NECK PAIN	NERVOUSNESS
GASTRIC REFLUX	CHRONIC SINUS	THYROID ISSUES	DISC PROBLEMS	MID BACK

Other: _____

CIRCLE ANY CONDITION YOU HAVE NOW/HAVE HAD:

Stroke Cancer Heart Disease Seizures Spinal Bone Fracture Scoliosis Diabetes

List all surgical operations and years: _____

_____

List all over the counter & prescription medications you are on:

_____ _____ _____

_____ _____ _____

When was your last auto accident? _____

Have you had previous chiropractic care YES/NO
If you have, who did you see and when? _____

Have you ever been knocked unconscious? YES/NO

Fractured a bone? YES/NO
If yes, please describe_____

Other trauma: _____

Do you view your health as an investment or expense? _____
How committed are you to living a healthier life on a scale of 1-10 with 10 being the healthiest life possible? _____

How would your life change if you didn't have the health conditions you indicated on this form?

_____

WRITTEN CONSENT FOR A MINOR CHILD

Name of Practice Member who is a Minor Child _____

I authorize Dr Melissa Arnold to perform diagnostic procedures, render chiropractic care and perform chiropractic adjustments and therapies to my minor child.

As of this date, I have the legal right to select and authorize health care services for my minor child. If my authority to select and authorize care is revoked or altered,

I will immediately notify Total Wellness Solutions.

_____ _____

DATE **GUARDIAN SIGNATURE**

_____ _____

WITNESS SIGNATURE **GUARDIAN'S RELATIONSHIP TO MINOR CHILD**

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE PRACITIONERS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

DATE _____

PLEASE PRINT YOUR NAME HERE _____

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGHT BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOLDER PAIN					
SINUS TROUBLE					
TMJ					
Other					

Total Wellness Solutions Terms

When a patient seeks wellness care and/or chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goal – To locate, analyze and correct spinal interference to the nerve system. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

We do not diagnose conditions of disease other than that which relates to vertebral subluxations (spinal misalignments). However, if during the course of a chiropractic spinal exam, should we encounter complaints that warrant medical attention, we will recommend that you seek the services of a provider who specializes in that area. We offer no treatment of conditions other than that which relate to vertebral subluxations. Our primary role is to identify subluxations and our primary method of correcting them is through spinal adjustments.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service (excluding work comp hereby authorize the doctor to examine and render care. By signing below, I agree to all the terms outlined.

Patient or Guardian's Signature X_____**Date:**____

Female Patients Only - Non-Pregnancy Verification for certain therapies

Let it be known by all people by my signature that I am not pregnant. If it later becomes known that I was pregnant during this therapy (or x-ray if applicable) that I do not hold the Center for Total Wellness Solutions LLC or Dr Melissa Arnold DC liable.

Patient or Guardian's Signature X_____**Date:**____

Children & Minors Only – Consent to Treat a Minor

I hereby authorize the doctor and whomever she may designate as assistants to examine and administer chiropractic care as deemed necessary to my child(ren).

Names of children: _____ _____ _____ _____

Patient or Guardian's Signature X_____**Date:**____

Health Care Authorization

Every medical and non-medical doctor in the United States is required by law effective April, 2003 to have patients sign the following authorization form which protects the privacy of your personal health/medical records. This form is for your benefit. If you have any questions, please do not hesitate to ask the office manager.

Patient's Full Name _____

Date of Birth _____/_____/_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES TOTAL WELLNESS SOLUTIONS/ DR MELISSA ARNOLD TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to Total Wellness Solutions to use my address, phone number, e-mail and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, promotions, events, and information about treatment alternatives or other health related information.

If Total Wellness Solutions contacts me by phone at home, work or on my cell phone, I give permission to the office staff to leave a phone message on my answering machine or voice mail.

I give Total Wellness Solutions permission to use pictures of myself taken in the office and testimonials that I either write or record on video for promotional purposes only.

I give Total Wellness Solutions permission to treat me in an open room where other patients may also be treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I ask to speak with the doctor at any time in private, the doctor will provide a room for these conversations. I understand that I may choose treatment in a private room rather than in the open adjusting or treatment suite.

I give permission to Total Wellness Solutions to speak to me about treatment or report of findings in front of my spouse or children if I choose to bring them to my appointments.

By signing this form, you are giving Total Wellness Solutions permission to use and disclose your protected health information in accordance with the directives listed above.

Patient or Guardian's Signature X _____Date:_____

Thank you for choosing the Center for Total Wellness Solutions LLC with Melissa Arnold DC. We look forward to being of service to you. We kindly ask you to call 24-hours in advance if you must cancel or reschedule your appointment to avoid missed appointment charge. Directions to Total Wellness Solutions can be found on our website, www.TotalWellnessSolutionsATL.com

The office is located at 5252 Roswell Road Suite 103 Atlanta GA 30342. At the corner of Mt Paran and Roswell road. We are around the back of the building at Coldwell Banker.
Please allow approximately 60-minutes for your initial office visit. We schedule new patients at different times than established patients so that you may be seen promptly and the office flow runs smoothly. Welcome to Total Wellness!