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Washington, PA 15301
Phone: (724) 222-8322



Dr. Tony Wano
Certified Chiropractic Sports Practitioner

WEIGHT LOSS & NUTRITION CENTERS, INC.

REGISTRATION OF INFORMATION

Date: _____

PLEASE PRINT

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

Home Phone: (____) _____

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

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

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

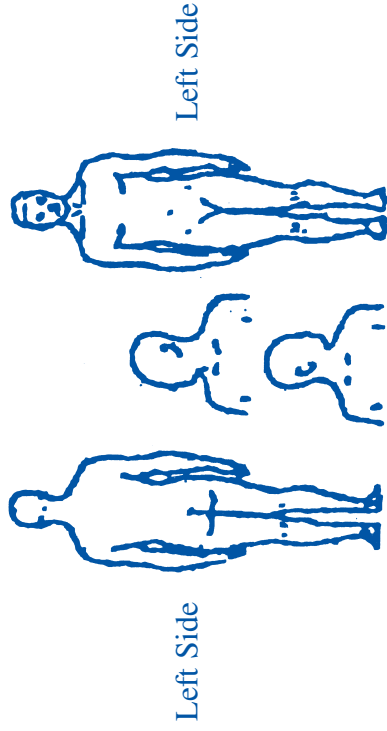
MEDICAL HISTORY

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. What doctors have you seen and what tests have been done for your condition? _____
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? _____
18. Do you have any other problems that you would like the doctors to evaluate? _____



PAST HISTORY

1. Have you had any of the following diseases: (Circle) Measles, Rubella, Chickenpox, Mumps, Scarlet Fever, Rheumatic Fever, Tuberculosis, HIV, Hepatitis, Other: _____
2. Have you been diagnosed with any other conditions? Y N Explain: _____
3. Are you under a doctor's care presently for any type of health problem? _____
4. Have you had any broken bones? Y N Which ones? _____
5. Have you ever had any past significant auto accidents, work injuries or falls? Y N When? _____
6. Are you taking any medications? Please list. _____
7. Have you ever undergone any type of surgery? What and when? _____
8. Do you smoke, drink alcohol or use recreational drugs? _____
9. Do you have any allergies? _____
10. Do any diseases run in the family? _____

SYSTEM REVIEW

HAVE YOU BEEN DIAGNOSED OR BEEN TOLD YOU HAVE THE FOLLOWING?

- | | | | |
|-----|--|-----|---|
| Y N | High blood pressure | Y N | Slurred speech or other speech problems |
| Y N | Hardening of the arteries | Y N | Difficulty swallowing |
| Y N | Diabetes | Y N | Dizziness |
| Y N | Heart or blood vessel disease | Y N | Temporary lack of understanding |
| Y N | Bone spurs on the neck (cervical spondylosis) | Y N | Loss of consciousness, even momentary blackouts |
| Y N | Whiplash injury | Y N | Numbness or loss of sensation in the face, arms, hands, fingers, or legs |
| Y N | Have any of your relatives ever suffered a stroke? | Y N | Any other abnormal or loss of sensation in any other part of the body |
| Y N | Blurred vision | Y N | Weakness, clumsiness, or strength loss in the face, arms, hands, fingers, or legs |
| Y N | Double vision | Y N | ringing, buzzing, or any noise in the ears |
| Y N | Diminished or partial loss of vision in one or both eyes | | |
| Y N | Complete loss of vision in one or both eyes | | |
| Y N | Sudden collapse without loss of consciousness | | |
| Y N | Hearing loss in one or both ears | | |

WOMEN ONLY

Do you experience any of the following symptoms?

- Y N Do you take birth control pills? How long? _____
- Y N Menstrual pain _____
- Y N Cramping _____
- Y N Irregularity _____
- Y N Date of last period _____ How long? _____
- Y N Are you now pregnant? _____ How long? _____

MEN ONLY

Date of last prostate exam: _____

- Difficulty with urination? Y N Explain _____
- Excessive urination? Y N Explain _____

I hereby consent to any procedures or treatments for any condition as deemed necessary by the attending doctors at **Wano Chiropractic Weight Loss & Nutrition Centers, Inc.**

Patient's Signature: _____ Date: ____/____/____