The Wellness Institute of Nashville
252 Jackson Meadow Drive
Hermitage, TN 37076

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WellnessInstTn.com

The WELLNESS INSTITUTE of Nashville
NO SURGERY, NO EXTRA MEDICATION, JUST RELIEF

PATIENT INFORMATION and TREATMENT APPLICATION

TELL US ABOUT YOU

PATIENT NAME _____

Mr. / Mrs. / Ms.

DATE OF BIRTH _____/ _____ / _____ SOCIAL SECURITY: _____- _____ -_____

HOME STREET ADDRESS _____

_____

STATE _____ ZIP CODE: _____

INSURANCE PROVIDER _____
(PLEASE PROVIDE COPY)
SUBSCRIBER ID: _____ GROUP: _____
CO-PAY AMOUNT: _____

EMAIL ADDRESS _____

TELEPHONE: #1 _____
#2 _____
#3 _____

OCCUPATION _____

SPOUSES NAME _____

WERE YOU REFERRED? Y N
If so, by whom? _____

PAIN SCALE 1 THRU 10	DATE OF ONSET

CIRCLE ALL THAT APPLY

COMPLAINT

BACK PAIN Upper Middle Low History of Injury/Surgery

NECK PAIN All Left Right History of Whiplash/Injury/Surgery

SHOULDER PAIN Bilateral Left Right

HEADACHE Migraines Chronic History of Injury/Concussion

JOINT PAIN Hand(s) Wrist(s) Elbow(s) Knee(s) Hip(s) Ankle(s)

CARPAL TUNNEL Bilateral Left Right History of Injury/Surgery

DISC ISSUES Dislocation Reported Bulging Reported Degeneration
History of Inury/Surgery
If location or disc number is known, please list:

Do you experience numbness or tingling? YES NO

Does your pain improve or worsen with movement? YES NO

What relieves your pain?

Does the pain radiate to different locations? YES NO

How often do you experience these symptoms? 100% 75% 50% 25% of the time

Does it affect your quality of life? YES NO

Are you currently taking prescription or OTC pain relievers? YES NO
If so, please list: _____ _____