WILSON WELLNESS

KOR THERAPY

**WILSON WELLNESS**
Helen Wilson
D.O.M.P., D.Sc.O., M.B.A., B.S.
Osteopathic Manual Practice

**KOR THERAPY**
Lymphatic Drainage Therapy, Reflexology,
Cranialsacral Therapy, and other modalities

# Patient Information Form

Please fill out this form & email to Admin@WilsonWellness.Com within 2 business days after you are given the website information.

Please wear comfortable and stretchy clothing so we can easily see and feel the position of your body as we move through the session. A t-shirt and a pair of stretchy shorts is ideal. Knees must be visible
This is a fragrance free office. Please refrain from wearing perfumes, colognes, or scented lotions.
The session will be held at the Wilson Wellness Clinic:
The Woodward Building • 25600 Woodward Ave., Suite #205 • Royal Oak, MI, 48067

**If you have any questions, please text (248) 579-5535 or call (248) 237-3104.**

I prefer to be contacted by _____ Text _____ Email _____ Phone

The best times to contact me are: _____

My preferred appointment times are: _____

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Contact Info: (please indicate preferred primary number)

Cell: _____ Home: _____

Work: _____ E-mail: _____

Emergency Contact: (please indicate preferred primary number)

Name: _____ Relationship: _____

Cell: _____ Work: _____

Who may we thank for referring you? _____

# Intake Questions

- Do you currently exercise? (How often and what type?)

- Are you currently working? If so, what type of work do you do? Is your job sedentary, mildly active; active, or very active?

- Do you currently suffer from any physical limitations, chronic or intermittent pain? (Please indicate month, year started, and describe symptoms.)

- Do you have any specific concerns that have brought you to a private session? (When and how did it/they start.)

- What are you hope to achieve from treatment?

- What would you like to be able to do that you can't do currently?

- Have you had surgery? If yes, please indicate type of surgery, the reason for the surgery, and the month and year when you had the surgery. Please include C-sections and any outpatient procedures.

- Have you ever undergone plastic/cosmetic surgery or received Botox treatments? Please include face lifts, eye lifts, chin tucks, or other cosmetic type surgeries. (Indicate type of surgery and year procedure was done.)

- Have you ever had any dental or orthodontic work done? (Fillings, caps, root canal, braces, etc. please indicate the number and if upper, lower, left or right.)

- For female patients: Have you ever been pregnant? How many children do you have? (Indicate number of pregnancies and include any adoptions.) Were the pregnancies long or hard? Any c-sections? Episiotomies, or rips or tears during episiotomies? Any complications during pregnancy or postpartum?

- Do you remember having any falls? (Indicate type of fall, year and month that it happened, even if many years ago.)

- Have/do you participate in any sports? (Indicate the years played and type of sport, even if many years ago.)

- Have you broken any bones? (Please indicate bones that were broken, month and year and how they got broken.)

- Do you have any scars? (Indicate the month and year as well as how they occurred.)

- Have you ever been involved in a motor vehicle accident? (Indicate month and year and if you were the driver or passenger, and if you were wearing a seatbelt.)

- Have you ever suffered from any serious illnesses? (Ex: diabetes, bronchitis, pneumonia, cancer, etc., indicate year.)

- Have you ever been or are you currently diagnosed with any conditions? (Indicate year of onset and year of diagnosis.)

- Have you ever had an MRI, X-ray, CAT scan, ultrasound, etc.? (Indicate what the diagnosis was as well as the year and month you received these.)

- Are you currently on any medication? (Indicate type, dosage, and what it is taken for.)

- Are you currently taking any supplements? (Indicate type, dosage, and what it is taken for.)

- Do you have any allergies? (Indicate to what and onset and severity).

- Do you have asthma, hay fever, or any sinus issues? (Indicate onset and treatment.)

- Have you ever tried any other forms of treatment that have been successful? (Physical therapy, chiropractic, etc. Indicate the type and the year you received these treatments.)

- Have you ever tried any other forms of treatment that have NOT been successful? (Indicate the type of treatment and year received.)

- Name of primary care physician: _____

  Phone: _____

  Address: _____

- How is your digestion overall? (How many bowel movements per day? What is your stool consistency? ex. loose, solid; constipated, diarrhea.)

- How is your sleep overall? (How many hours per night do you sleep? Do you have trouble sleeping, falling asleep, or staying awake? Do you awaken at the same time nightly? If so, what time?)

- Is there anything else that you would like me to be aware of?

# Osteopathic Manual Practice, Ear Acupuncture/Seeds, Other Procedures and Treatments Consent to Treatment

I hereby request and consent to the performance of Osteopathic Manual Practice, lymphatic drainage, cranial sacral therapy, reflexology, ear acupuncture/seeds, cupping, infrared sauna, and other procedures and treatments offered at Wilson Wellness or KOR Therapy on me (or the patient name below for which I am legally responsible) by the below name.

I understand the methods or treatments may include but are not limited to osteopathic manual practice, lymphatic drainage, cranial sacral therapy, reflexology, ear acupuncture/seeds, microcurrent therapy, infrared sauna, and other treatments and procedures.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below agree to the above-named treatments and procedures. I also understand there's always a possibility of an unexpected complication. I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. _____(initials)

I understand that the practitioner is a DOMP or other type of practitioner and is not an MD physician and cannot provide healthcare normally received from an MD. I also understand that if I have a serious problem or condition or I want someone to go over the details of my medical history from a medical doctor, neurologist, or orthopedic perspective, that I should see my family doctor/primary care physician and be referred to the appropriate doctor. I understand that this practitioner can provide complementary care and I realize that I must take responsibility for my own health. Furthermore, I understand that it is appropriate for me to consult with my primary care physician about the manipulative and or ear acupuncture treatment if I choose to do so, or if the practitioner recommends such a consultation. And I understand that I should inform the practitioner whether or not a licensed physician has examined me with regard to the issues.

I understand it may be necessary for my practitioner to contact another one of my healthcare providers in order to coordinate medical treatment, to discuss an emergency situation, and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____ (initials)

I understand and agree that the best way for Wilson Wellness and KOR therapy to keep me informed of my appointment reminders and products/services is to communicate through email and SMS text messaging. I give consent and opt in to allow them to contact me directly for this and know I have the right to opt out of the service at any time._____

I agree to pay the full charge for any missed or forgotten appointments without 48-hour notice of cancellation. _____ (initials)

Wilson Wellness in Michigan does not participate in nor accept any insurance; this includes Medicare. Patients are responsible for full payment at the time of service. _____ (initials)

_____
Patient's Name

_____
Patient's Signature

_____
Date Signed

**Helen Wilson**
_____
Name of DOMP

_____
Name of Other Practioner

To be completed by the patient's representative, if the patient is a minor, or physically / legally incapacitated.

_____
Name of Patient

_____
Patient's Representative

_____
Relationship or Authority of Patient

_____
Witness

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# Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

## Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

☐ Other _____

Cardholder Name (as shown on card):_____

Card Number:_____

Expiration Date (mm/yy): _____

CVV: _____ Cardholder Postal Code (from credit card billing address): _____

I, _____ , authorize Wilson Wellness or KOR Therapy and it's practitioners to charge my credit card above for agreed upon purchases (which may include but are not limited to osteopathic manual practice, ear acupuncture/seeds, microcurrent therapy, infrared sauna, and other treatments and procedures offered by Wilson Wellness). I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

- Cancellations more than 48 business hours before scheduled appointment time: No charge.
- Cancellations less than 48 business hours, if we are unable to fill appointment full fees apply. If we are able to fill appointment there is a $25 rescheduling fee, charged to credit card on file or patient can pay by other payment method.
- No show: 100% of full clinic price (+ card company processing fees) charged to credit card on file.
- All cancellations can be made by text, or phone/voice message; text preferred, cancellations are not accepted by email.

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