Wilson Wellness
Helen Wilson
Helen Wilson, D.O.M.P., D.Sc.O.

Osteopathic Manual Practice | Craniosacral Therapy | Spinal Flow | Lymphatic Deep Tissue & Therapeutic Massage | Additional Complementary Therapies

Patient Information Form

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

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.

Reminder: 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.

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 can we thank for referring you? ____

Intake Questions

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

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

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

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

5. What is your main goal for this treatment?

6. What would you like to be different about your current situation?

7. 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.

8. 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.)

9. 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.)

10. 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?

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

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

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

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

15. 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.)

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

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

18. 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.)

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

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

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

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

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

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

25. Name of primary care physician: ______________________________

    a. Phone: ______________________________

    b. Address: ______________________________

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

27. 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 wake up at the same time at night? If so, what time?)

28. Is there anything else that you would like us to be aware of?

29. I understand that I should wear comfortable, stretchy clothing to my appointment so the practitioner can properly assess and work with my body. A T-shirt and stretchy shorts (or similar) are recommended, and knees should be visible.
    ☐ No
    ☐ Yes

30. I understand that Wilson Wellness is a fragrance-free office, and I agree to refrain from wearing perfumes, colognes, or scented lotions to my appointment.
    ☐ No
    ☐ Yes

31. Tobacco Use
Do you currently smoke or use tobacco products?
☐ No
☐ Yes

If yes, please indicate type:
☐ Cigarettes ☐ Vaping ☐ Cigars ☐ Other: ___________

Average use:
☐ Less than 1 per day
☐ 1–5 per day
☐ 6–10 per day
☐ 10+ per day

32. Alcohol Use
Do you consume alcohol?
☐ No
☐ Yes

If yes, frequency:
☐ Occasional (less than 1x/week)
☐ Weekly
☐ Several times per week
☐ Daily

Typical amount per occasion:
☐ 1 drink
☐ 2–3 drinks
☐ 4–5 drinks
☐ 6+ drinks

33. Cannabis Use
Do you currently use cannabis or marijuana products?
☐ No
☐ Yes

If yes, type:
☐ Smoking ☐ Edibles ☐ Oils/Tinctures ☐ Vaping ☐ Other: ___________

Frequency:
☐ Occasional (less than 1x/week)
☐ Weekly
☐ Several times per week
☐ Daily

Osteopathic Manual Practice, NADA: Ear Acupuncture/Seeds

Consent to Treatment and Cancellation Policy

Consent to Treatment

I hereby request and consent to assessment and treatment at Wilson Wellness by its practitioners, including but not limited to Osteopathic Manual Practice, Lymphatic Drainage, Cranial Sacral Therapy, NADA: Ear Acupuncture/Seeds, Cupping, Infrared Sauna, Microcurrent Therapy, and other complementary therapies offered by the clinic.

I understand the methods of treatment proposed may include, but are not limited to Osteopathic Manual Practice, Lymphatic Drainage, Cranial Sacral Therapy, NADA: Ear Acupuncture / Seeds, Microcurrent Therapy, Infrared Sauna, and Adjunctive Therapies. I understand that the specific treatments provided will be based on my individual needs and the practitioner's assessment.

I have been informed that I have the right to refuse any form of treatment. I have read, or have had read to me, this consent and understand that I have the right to ask questions, request modifications, or refuse any Treatment at any time without affecting my future care.

I understand that there are potential risks associated with treatments and that no guarantees of results have been made. This consent applies to current and future visits unless withdrawn in writing.

Scope of Practice

I understand that practitioners at Wilson Wellness (including DOMPs and complementary providers) are not Medical Doctors and do not diagnose medical conditions, prescribe medications, or provide physician-level services.

I understand that this care is complementary and does not replace medical care. I am responsible for consulting a licensed physician for diagnosis or medical concerns and agree to inform my practitioner of any relevant health conditions or changes.

Coordination of Care

I authorize Wilson Wellness to communicate with other healthcare providers when necessary for coordination of care or in the event of an emergency, in accordance with applicable privacy laws.

Communication & SMS Consent

I consent to receive appointment reminders, scheduling updates, clinic notifications, and occasional promotional messages via SMS and email.

I understand:

- **Message frequency may vary**
- **Message and data rates may apply**
- **I can opt out at any time by replying STOP**
- **I can reply HELP or contact the clinic for assistance**

I understand that consent to SMS communication is not required for treatment and may be withdrawn at any time.

Signature: ______________________________ Date: _________________

Appointment Responsibility & SMS Notice

Patients are responsible for keeping track of their appointment times. SMS reminders may be sent as a courtesy but are not guaranteed. The cancellation policy still applies whether or not a reminder is received.

☐ I understand and agree with the above.

Cancellation Policy

Your appointment time is reserved for you. Late cancellations and missed appointments impact on our practitioners and other patients.

New Patient Appointments

• $25 non-refundable deposit required (applied to first visit)

• 4 business days' notice required for changes or cancellations

Routine Appointments

• 2 business days' notice required

• Business days: Monday–Friday

Fees

• Proper notice: No charge

• Late cancellation: 100% of appointment fee charged

• No-show: 100% of appointment fee charged

How to Cancel

• Text or phone/voicemail (text preferred)

• Email cancellations are not accepted

Acknowledgement & Consent

☐ I have read and understand this information

☐ I have had the opportunity to ask questions

☐ I voluntarily consent to assessment and treatment

Patient Name: ____________________________

Signature: _______________________________ Date: ___________

(If applicable)

Representative Name: _____________________

Relationship: _____________________________

Signature: _______________________________

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 and its 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

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