

Living Well Chiropractic

PATIENT HISTORY

(Please Print, All information is confidential)

Name: _____	Email: _____	Spouse's Name: _____
Address: _____	DOB: _____ Age: _____	Emergency Contact: _____
City, State, Zip: _____	SS #: _____	Relationship: _____
_____	Referred By: _____	Insurance Name: _____
Home Phone: _____	Marital Status: _____ # of children: _____	Insurance phone # _____
Office Phone: _____	Occupation: _____	<i>If you have insurance please present your card to the front desk so we can copy it.</i>
Cell Phone: _____	Employer: _____	

If patient is a minor (under 18yrs old), Please fill out this section. If not, skip:

Parent/ Guardian's Name: _____ Date of Birth: _____ Age: _____

Address: _____ City/State: _____ Zip: _____ Phone # _____ SS# _____

Occupation: _____ Employer: _____ Work Phone: _____

Chief Complaint or reason for today's visit? _____

How long have you had this condition? _____ Date of Onset? _____

Have you had this condition before? _____ If yes, when? _____

Is the condition related to: Work () Auto () Date of Accident: _____ Have you lost days form work? _____

What doctors have you seen for this condition? _____

What did they do? _____

When was your last visit to a Chiropractor? _____ Were you helped? _____

What Spinal Correction programs were you given? _____

Did you follow it? _____ If not, why? _____ How did the post X-Rays look? _____

What surgeries have you had? _____

List drugs you now take (prescription & non-prescription): _____

Are you currently wearing: Heel lifts _____ Arch Supports _____ Back Brace _____

<input type="checkbox"/> Fractured Bones	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Auto Accidents	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Liver Trouble
<input type="checkbox"/> 0-1 years ago	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Blurred Vision R L	<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> 1-5 years ago	<input type="checkbox"/> Trouble Concentrating	<input type="checkbox"/> Double Vision R L	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> More than 5	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Upper Back Pain/Stiffness	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Other Accidents/Falls	<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Mid Back Pain/Stiffness	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Back Curvature	<input type="checkbox"/> Headache	<input type="checkbox"/> Low Back Pain/Stiffness	<input type="checkbox"/> Diarrhea/Constipation
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pain/Stiff Neck R L	<input type="checkbox"/> Numbness, Tingling or Pain	<input type="checkbox"/> Colon Trouble
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Numbness/Tingling/Pain	in buttocks, thighs, legs, feet, toes	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Swollen/Painful Joints	Arms/Hands/Fingers R or L	<input type="checkbox"/> Pain with cough, sneeze	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Jaw Pain/TMJ R L	<input type="checkbox"/> Hip Pain R L	<input type="checkbox"/> Impotence
<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Head/Shoulders Feel Tired	<input type="checkbox"/> Foot Trouble R L	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Cancer	<input type="checkbox"/> Difficulty in Excessive	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Menstrual Problem/PMS
<input type="checkbox"/> Frequent Colds/Flu	(Standing, Walking, Bending, Riding,	<input type="checkbox"/> Asthma	<input type="checkbox"/> Menopausal Problems
<input type="checkbox"/> Depressed	Twisting, Lifting, Household Duties)	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Pregnant (now)
<input type="checkbox"/> Irritable	<input type="checkbox"/> Shoulder Pain R L	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Anemia	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Ear Infection
<input type="checkbox"/> Tremors	<input type="checkbox"/> Ringing in Ears R L	<input type="checkbox"/> Stroke	<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Allergies	<input type="checkbox"/> Hearing Loss R L	<input type="checkbox"/> High/Low Blood Pressure	

Please mark X for present conditions, O for past conditions

Name: _____

Date of Birth: _____

Symptomatology: (continued from page one)

Problem Area #1

The pain is located _____

The pain started _____

The pain is made better by _____
and worse by _____

How would you describe the pain: _____

 There is There is not referred or radiating pain into _____ There is There is not parasthesia (tingling/numbness) into: _____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.) _____

On a scale of 1- 10 rate your pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain****Additional Area #2**

The pain is located _____

The pain started _____

The pain is made better by _____
and worse by _____

How would you describe the pain: _____

 There is There is not referred or radiating pain into _____ There is There is not parasthesia (tingling/numbness) into: _____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.) _____

On a scale of 1- 10 rate your pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain****Additional Area #3**

The pain is located _____

The pain started _____

The pain is made better by _____
and worse by _____

How would you describe the pain: _____

 There is There is not referred or radiating pain into _____ There is There is not parasthesia (tingling/numbness) into: _____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.) _____

On a scale of 1- 10 rate your pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain**

Living Well Chiropractic

THIS DOCUMENT COSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental and social well being, not merely the absence of disease, symptoms or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of the health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression to the body's innate wisdom. Our only method is the specific adjustment of vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

POLICIES

1. All first visit charges are payable when services are rendered, since it is impossible to determine what insurance covers without a diagnosis of severity.
2. The fee paid for X-rays is for the analysis of those X-rays only. The film itself is the property of this office. Original X-rays can not be released; however, copies can be made at minimal charge.
3. I have read Living Well Chiropractic's Notice of Patient Privacy Practices.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Living Well Chiropractic (LWC) will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to LWC will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment.

In case of emergency, notify _____ Phone # _____

I, _____, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis. _____
(Signature) (Date)

COMPLETE IF THE PATIENT IS A MINOR CHILD: child's name: _____

I, _____ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

(Signature) (Date)