WELCOME

PATIENT INFORMATION

DATE____

FIRST NAME__________________________________

LAST NAME___________________________________

ADDRESS_____________________________________

CITY____

STATE_______________________ZIP_____________

EMAIL_______________________________________

SEX (CIRCLE) M F AGE__________

BIRTHDATE_______________________________

MARITAL STATUS ( ) MARRIED ( ) SINGLE

( ) MINOR ( ) WIDOWED ( ) DIVORCED

OCCUPATION__________________________________

WHO IS YOUR PRIMARY CARE PHYSICIAN?

____

WHOM MAY WE THANK FOR REFERRING YOU?

____

PHONE NUMBERS

HOME PHONE (______)_____________________

CELL PHONE (______)_____________________

CELL CARRIER________________________________

EMERGENCY CONTACT INFORMATION:

NAME:_______________________________________

PHONE NUMBER:_______________________________

RELATIONSHIP:_______________________________

INSURANCE AND PAYMENT INFORMATION

HOW WILL YOU PAY TODAY? ( ) CASH

( ) INSURANCE

INSURANCE ONLY

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents have insurance coverage with the card I present to this office and assign directly to Live Well Chiropractic all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

Live Well Chiropractic may use my health care information and may disclose such information my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Are you the **primary** cardholder? ( ) yes ( ) no

If not, please list the primary cardholder's name and date of birth____

____

____

Signature of Patient, Parent or Guardian

____

Please print name of Patient, Parent or Guardian

ACCIDENT INFORMATION

IS THIS DUE TO AN ACCIDENT? ( ) YES ( ) NO

DATE____

TYPE OF ACCIDENT ( ) AUTO ( ) WORK ( )HOME ( ) OTHER

TO WHOM HAVE YOU REPORTED YOUR ACCIDENT?

( ) AUTO INS. ( ) EMPLOYER ( ) WORK COMP

ATTORNEY NAME:______________________________

HEALTH HISTORY

TELL US WHATS WRONG

REASON FOR VISIT_______________________________________

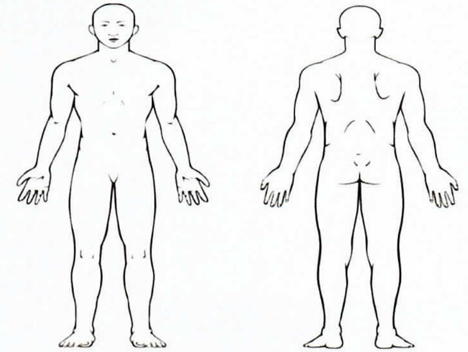
WHEN DID YOUR SYMPTOMS APPEAR?_______________________

IS IT GETTING WORSE? ( ) YES ( ) NO ABOUT THE SAME ( )

WHAT TYPE OF PAIN IS IT?__________________________________

HOW BAD IS YOUR PAIN? 1---10

MILD PLACE AN "X" ON THE LINE SEVERE



Mark Your Pain Above

TELL US MORE ABOUT IT

WHAT OTHER TREATMENTS HAVE YOU TRIED?____
WHAT OTHER DOCTORS HAVE YOU SEEN?____
HAVE YOU HAD AN X-RAY, MRI, OR CT-SCAN FOR THIS PROBLEM? ( ) YES ( ) NO
IF SO, DID YOU BRING THEM? ( ) YES ( ) NO

HAVE YOU HAD SURGERY ON ANY WEIGHT BEARING JOINTS? (KNEES, FEET, HIP, ANKLES)? ( ) YES ( ) NO
HAVE YOU HAD SURGERY ON THE PROBLEM YOU ARE HERE FOR TODAY? ( ) YES ( ) NO
HAVE YOU EVER BEEN TOLD YOU HAVE THIN BONES OR OSTEOPOROSIS? ( ) YES ( ) NO]
HAVE YOU EVER BROKEN A RIB? ( ) YES ( ) NO

ARE YOU TAKING OTC MEDICATIONS OR PRESCRIPTION MEDICATIONS FOR THIS PROBLEM? ( ) YES ( ) NO
HAVE YOU EVERY BEEN TOLD YOU HAVE SCOLIOSIS? ( ) YES ( ) NO
HAVE YOU HAD SPINAL SURGERY? ( ) YES ( ) NO

TELL US ABOUT OTHER HEALTH ISSUES YOU MAY HAVE

LIST ANYTHING YOU HAVE BEEN TREATED FOR IN THE LAST YEAR?________________________________
LIST ANY OTHER DIAGNOSIS YOU HAVE BEEN TOLD YOU HAVE____________________________________

EXERCISE	WORK ACTIVITY	HABITS
( ) NONE	( ) SITTING	( ) SMOKING HOW LONG?_________
( ) MODERATE	( ) STANDING	( ) ALCOHOL HOW MANY PER WEEK?_____
( ) DAILY	( ) LIGHT LABOR	( ) CAFFEINE HOW MANY PER WEEK?_____
( ) HEAVY	( ) HEAVY LABOR	( ) HIGH STRESS REASON?___________

MEDICATIONS	ALLERGIES	SURGERIES	BROKEN BONES	VITAMINS