Live Well Chiropractic
CHIROPRACTIC, MASSAGE AND NUTRITION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YYYY)_____ **Whom may we thank for referring you?** _____

PERSONAL

Last Name _____ **First** _____ **Middle(or Initial)** _____

Street Address _____

City _____ **State/Province** _____ **ZIP/Postal Code** _____

Home Phone _____ **Cell** _____ **Email Address** _____

Gender ❍ Male ❍ Female **Birth Date** (MM/DD/YYYY) _____ **Social Security Number** _____

Marital Status ❍ Single ❍ Married ❍ Divorced ❍ Widowed ❍ Separated **Spouse's Name** _____

Children (names and ages) _____

Occupation _____

Employer _____ **Phone** _____

Street Address _____

City _____ **State/Province** _____ **ZIP/Postal Code** _____

May we contact you at work? ❍ Yes ❍ No **Preferred method of contact** ❍ Home Phone ❍ Cell Phone ❍ Work Phone ❍ Email

Primary Care Physician _____ **Phone** _____

INSURANCE

Insurance Carrier _____ **Policy Number** _____ **Carried by** ❍ Self ❍ Spouse ❍ Parent

Insured's Last Name _____ **First** _____ **Middle(or Initial)** _____

Insured's Birth Date (MM/DD/YYYY) _____ **Social Security Number** _____

Insured's Employer _____ **Phone** _____

Street Address _____

City _____ **State/Province** _____ **ZIP/Postal Code** _____

EMERGENCY CONTACT

Last Name _____ **First** _____ **Middle(or Initial)** _____

Relationship _____

Home Phone _____ **Cell** _____ **Email Address** _____

Live Well Chiropractic
Chiropractic, Massage and Nutrition

The symptom(s) that have prompted me to seek care include: _____

_____

And are the result of: ❍ An accident or injury – ❍ Work ❍ Auto ❍ Other _____

❍ A worsening long term problem ❍ An interest in: ❍ Wellness ❍ Other _____

Onset: When did you notice current symptoms _____ **4. Intensity:** How extreme are your current symptoms? **0** ❍-❍-❍-❍-❍-❍-❍-❍-❍-❍ **10**
Absent Uncomfortable Agonizing

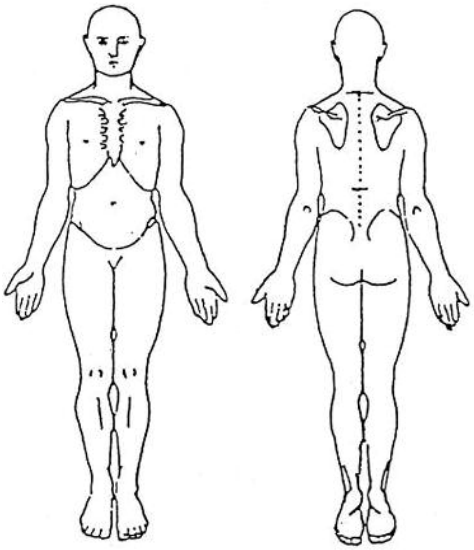
Duration and timing: How often do you feel your symptoms? ❍ Constant ❍ Comes and goes How often? _____

Quality of symptoms: What does it feel like?

❍ Numbness ❍ Tingling ❍ Stiffness ❍ Dull ❍ Aching ❍ Cramps ❍ Nagging ❍ Sharp ❍ Burning ❍ Shooting ❍ Throbbing ❍ Stabbing

❍ Other _____

Location: Were does it hurt? Circle area(s) on the illustration.
O for current condition, **X** for conditions experienced in the past



Radiation: To what areas, if any, does the pain radiate, shoot or travel?

_____

Aggravating or relieving factors: What makes it better or worse, such as time of day, movements, certain activities, etc.

Worsens pain _____

Lessens pain _____

Prior interventions: What have you done to alleviate the symptoms?

❍ Prescription medications (list) _____

❍ Over-the-counter drugs (list) _____

❍ Homeopathic remedies (list) _____

❍ Physical therapy ❍ Ice ❍ Heat ❍ Chiropractic ❍ Massage ❍ Acupuncture ❍ Surgery

❍ Other _____

What else should the Doctor know about your current condition? _____

How does your current condition interfere with your:

Work or career _____

Recreational activities _____

Household responsibilities _____

Personal relationships _____

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect	Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	❍	❍	❍	❍	Grocery shopping	❍	❍	❍	❍
Rising out of chair	❍	❍	❍	❍	Household chores	❍	❍	❍	❍
Standing	❍	❍	❍	❍	Lifting objects	❍	❍	❍	❍
Walking	❍	❍	❍	❍	Reaching overhead	❍	❍	❍	❍
Lying down	❍	❍	❍	❍	Showering or bathing	❍	❍	❍	❍
Bending over	❍	❍	❍	❍	Dressing self	❍	❍	❍	❍
Climbing stairs	❍	❍	❍	❍	Love life	❍	❍	❍	❍
Using a computer	❍	❍	❍	❍	Getting to sleep	❍	❍	❍	❍
Getting out of car	❍	❍	❍	❍	Staying asleep	❍	❍	❍	❍
Driving car	❍	❍	❍	❍	Concentrating	❍	❍	❍	❍
Looking over shoulder	❍	❍	❍	❍	Exercising	❍	❍	❍	❍
Caring for family	❍	❍	❍	❍	Yard work	❍	❍	❍	❍

Live Well Chiropractic
Chiropractic, Massage and Nutrition

MEDICAL HISTORY

Systems Review: Check the circles below for any condition you've **had** in the past or **have** currently.

Musculoskeletal	Had	Have
Osteoporosis	❍	❍
Arthritis	❍	❍
Scoliosis	❍	❍
Neck Pain	❍	❍
Back Problems	❍	❍
Hip Disorders	❍	❍
Knee Injuries	❍	❍
Foot/Ankle Pain	❍	❍
Shoulder Problems	❍	❍
Elbow/Wrist Pain	❍	❍
TMJ Issues	❍	❍
Poor Posture	❍	❍

Neurological	Had	Have
Anxiety	❍	❍
Depression	❍	❍
Headache	❍	❍
Dizziness	❍	❍
Pins and Needles	❍	❍
Numbness	❍	❍

Cardiovascular	Had	Have
High Blood Pressure	❍	❍
Low Blood Pressure	❍	❍
High Cholesterol	❍	❍
Poor Circulation	❍	❍
Angina	❍	❍
Excessive Bruising	❍	❍

Respiratory	Had	Have
Asthma	❍	❍
Apnea	❍	❍
Emphysema	❍	❍
Hey Fever	❍	❍
Shortness of Breath	❍	❍
Pneumonia	❍	❍

Sensory	Had	Have
Blurred Vision	❍	❍
Ringing in Ears	❍	❍
Hearing Loss	❍	❍
Chronic Ear Infection	❍	❍
Loss of Smell	❍	❍
Loss of Taste	❍	❍

Digestive	Had	Have
Anorexia/Bulemia	❍	❍
Ulcer	❍	❍
Food Sensitivities	❍	❍
Heartburn	❍	❍
Constipation	❍	❍
Diarrhea	❍	❍

Integumentary	Had	Have
Skin Cancer	❍	❍
Psoriasis	❍	❍
Eczema	❍	❍
Acne	❍	❍
Hair Loss	❍	❍
Rash	❍	❍

Endocrine	Had	Have
Thyroid Issues	❍	❍
Immune Disorders	❍	❍
Hypoglycemia	❍	❍
Frequent Infection	❍	❍
Swollen Glands	❍	❍
Low Energy	❍	❍

Genitourinary	Had	Have
Kidney Stones	❍	❍
Infertility	❍	❍
Bedwetting	❍	❍
Prostate Issues	❍	❍
Erectile Dysfunction	❍	❍
PMS Symptoms	❍	❍

Constitutional	Had	Have
Fainting	❍	❍
Low Libido	❍	❍
Poor Appetite	❍	❍
Fatigue	❍	❍
Sudden Weight Gain	❍	❍
Sudden Weight Loss	❍	❍
Weakness	❍	❍

Consultation Notes

Past Personal History: Identify your past health history, including illnesses you've had or have; surgeries; injuries; accidents and treatments including past and current. Please complete each section.

Illness	Had	Have
AIDS	❍	❍
Alcoholism	❍	❍
Allergies	❍	❍
Arteriosclerosis	❍	❍
Cancer	❍	❍
Chicken Pox	❍	❍
Diabetes	❍	❍
Epilepsy	❍	❍
Glaucoma	❍	❍
Goiter	❍	❍
Gout	❍	❍
Heart Disease	❍	❍
Hepatitis	❍	❍
HIV Positive	❍	❍
Malaria	❍	❍
Measles	❍	❍
Multiple Sclerosis	❍	❍
Mumps	❍	❍
Polio	❍	❍
Rheumatic Fever	❍	❍
Scarlet Fever	❍	❍
STD sexually transmitted disease	❍	❍
Stroke	❍	❍
Tuberculosis	❍	❍
Thyphoid Fever	❍	❍
Ulcer	❍	❍
Other	❍	❍

_____

Surgeries	
Appendix Removal	❍
Bypass	❍
Cancer	❍
Cosmetic	❍
Eye	❍
Hysterectomy	❍
Pacemaker	❍
Spine	❍
Tonsillectomy	❍
Vasectomy	❍
Elective	❍

_____

_____

Other ❍

_____

_____

_____

Injuries	
Broken/Fractured Bone	❍
Spine/Nerve Disorder	❍
Knocked Unconscious	❍
Auto Accident Injury	❍
Used Crutch or Support	❍
Used Neck or Back Brace	❍
Received a Tattoo	❍
Received a Body Piercing	❍

Medications prescription and over-the-counter

_____

_____

_____

_____

_____

_____

_____

Treatments	Past	Current
Acupuncture	❍	❍
Antibiotics	❍	❍
Birth Control Pills	❍	❍
Blood Transfusions	❍	❍
Chemotherapy	❍	❍
Chiropractic Care	❍	❍
Dialysis	❍	❍
Epilepsy	❍	❍
Herbs	❍	❍
Homeopathy	❍	❍
Hormone Replacement	❍	❍
Inhaler	❍	❍
Massage Therapy	❍	❍
Physical Therapy	❍	❍
Nutritional Supplements	❍	❍

_____

_____

Consultation Notes

Live Well Chiropractic
Chiropractic, Massage and Nutrition

Family History:

Relative	Age (if living)	State of Health Good	Poor	Illnesses	Age at death	Cause of death
Mother	_____	❍	❍	_____	_____	_____
Father	_____	❍	❍	_____	_____	_____
Sister1	_____	❍	❍	_____	_____	_____
Sister 2	_____	❍	❍	_____	_____	_____
Brother1	_____	❍	❍	_____	_____	_____
Brother 2	_____	❍	❍	_____	_____	_____
_____	_____	❍	❍	_____		

Are there any other hereditary health issues of which you are aware? _____

Social History:

Alcohol Use ❍ Daily ❍ Weekly ❍ Occasional How much? _____
Coffee Use ❍ Daily ❍ Weekly ❍ Occasional How much? _____
Tobacco Use ❍ Daily ❍ Weekly ❍ Occasional How much? _____
Exercising ❍ Daily ❍ Weekly ❍ Occasional How much? _____
Pain Relievers ❍ Daily ❍ Weekly ❍ Occasional How much? _____
Soft Drinks ❍ Daily ❍ Weekly ❍ Occasional How much? _____
Water Intake ❍ Daily ❍ Weekly ❍ Occasional How much? _____
Hobbies _____

Prayer or Meditation ❍ Yes ❍ No
Job Pressure/Stress ❍ Yes ❍ No
Relationships Stress ❍ Yes ❍ No
Financial Stress ❍ Yes ❍ No
Vaccinated ❍ Yes ❍ No
Mercury Fillings ❍ Yes ❍ No
Recreational Drug Use ❍ Yes ❍ No

Daily Living:

What is currently causing the most stress in your life? _____

How much sleep are you getting per night? _____Hours **What type and age are your mattress and pillow** _____

Preferred Sleeping Position ❍ Back ❍ Side ❍ Stomach

Typical Eating Habits ❍ Skip Breakfast ❍ Two Meals A Day ❍ Three Meals A Day ❍ Between Meal Snacks

In addition to the main reason for your visit, what are your other health goals? _____

_____

ACKNOWLEDGEMENTS

In order to set clear expectations, improve communication and help you attain the best results, please read each statement and initial your agreement.

_____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.
Date of last menstrual period (MM/DD/YYYY) _____

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information, as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non-covered services that I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)