Living Well Chiropractic
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NEW PATIENT HEALTH HISTORY

Welcome to Living Well Chiropractic!

PATIENT INFORMATION

First Name: _____ Last Name: _____

Preferred Name: _____ Referred by: _____

Occupation: _____ DOB: _____ / _____ / _____ Age: _____

Cell Phone: (_____) _____ - _____ Home Phone: (_____) _____ - _____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Home Address: _____ City: _____ Zipcode:_____

Email address: _____ SSN: _____ - _____ - _____

Spouse's Name: _____ Spouse's Health Status: _____

Have you even been under chiropractic care? ❒ Yes ❒ No

EMERGENCY CONTACT

Emergency Contact First Name: _____ Last Name: _____

Best Phone #: (_____) _____ - _____ Relationship to Patient: _____

Email address: _____

FAMILY HISTORY

Family Members – Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

_____

_____

_____

_____

INSURANCE

Primary Insurance Name: _____ Policy # : _____

Group # : _____ Phone #: (_____) _____ - _____

Policy Holder: ❒ Patient - or - Policy Holder Name: _____

DOB: _____ / _____ / _____ Relationship to Patient: _____

***If an auto accident, please provide:**

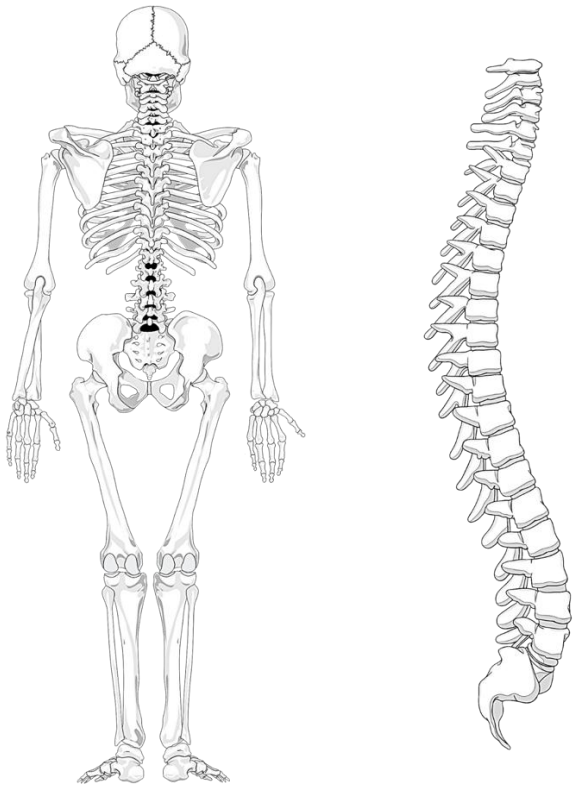
Insurance Company Name: _____ Contact Person: _____

Phone : _____ Claim #: _____

HISTORY OF PRESENT ILLNESS

Please mark on the body diagram where you are experiencing the following symptoms:

N = Numbness
B = Burning
S = Stabbing
T = Tingling
A = Dull Ache



CURRENT COMPLAINTS

Nature of Injury: ❒ Automobile ❒ Work ❒ Other What is the level of your pain (1-10) _____

Reason for your visit:

_____

_____

_____

When did your symptoms begin? _____

How often do you experience symptoms? _____

Does the pain radiate? ❒ Yes ❒ No

Describe the nature of your symptoms: ❒ Sharp ❒ Dull ache ❒ Numb ❒ Shooting ❒ Burning ❒ Tingling ❒ Stabbing ❒ Other: _____

What treatment have you already tried for your condition? ❒ Medication ❒ Surgery ❒ Physical Therapy ❒ Chiropractic Services ❒ None ❒ Other: _____

Are you currently under the care of a primary healthcare provider or any other doctor? ❒ Yes ❒ No

If yes: Provider's Name: _____ ❒ PCP ❒ Specialty: _____

Phone Number: (_____) _____ - _____ Date of last visit: _____ / _____ / _____

Date of last spinal imaging: _____ / _____ / _____ ❒ XR ❒ CT ❒ MRI ❒ Bone Scan ❒ *No recent imaging*

Anything else you would like your care team to know about? _____

_____

_____

PAST MEDICAL HISTORY *please check all that apply*

❒ AIDS/HIV	❒ Emphysema	❒ High blood pressure	❒ Parkinson's disease
❒ Alcoholism	❒ Epilepsy, seizures	❒ High cholesterol	❒ Pneumonia
❒ Allergy shots	❒ Fractures (broken bones)	❒ Liver disease	❒ Prostate problems
❒ Anemia	❒ Glaucoma	❒ Lupus	❒ Rheumatoid arthritis
❒ Arthritis	❒ Goiter	❒ Measles	❒ Stroke
❒ Asthma	❒ Gonorrhea	❒ Migraines, headaches	❒ Thyroid problems
❒ Bleeding disorders	❒ Gout	❒ Mononucleosis	❒ Tonsillitis
❒ Bronchitis	❒ Heart disease	❒ Multiple sclerosis	❒ Tuberculosis
❒ Cancer	❒ Hepatitis	❒ Osteoporosis	❒ Other: _____
❒ Diabetes	❒ Herniated disc	❒ Pacemaker, ICD	❒ Other: _____

CURRENT LIFESTYLE AND HEALTH STATUS

Do you exercise? ❒ Never ❒ A few days per week ❒ Daily Comments: _____

Work activity: ❒ Mostly sitting ❒ Sitting and standing ❒ Light physical labor ❒ Heavy physical labor

Smoking: ❒ Light ❒ Moderate ❒ Heavy Comments: _____

Alcohol: ❒ Light ❒ Moderate ❒ Heavy Comments: _____

Caffeine: ❒ Light ❒ Moderate ❒ Heavy Comments: _____

Any recent injuries? ❒ Dislocation ❒ Head injury ❒ Broken bone ❒ Fall ❒ Other: _____

List any medications, vitamins, supplements: _____

_____

_____

_____

List any allergies: _____

_____

ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS

Name of Insured: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: _____ Date: _____ / _____ / _____

Representative Signature: _____ Date: _____ / _____ / _____

Print Representative Name: _____ Relationship: _____