

New Patient Information

Name _____ Date _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Primary Phone # _____ Secondary Phone # _____

Email address _____ Work Phone _____

Employer _____ Occupation _____

Marital Status: **M S W D** Spouse's Name _____ Number of Children _____

How did you hear about our office? _____

Reason For Visit:

Health Problem Work Injury Auto Accident

I. HEALTH CONCERNS

List health concerns according to their severity	Rate the Severity 1 (mild) – 10 (worst imaginable)	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	% of time pain is present
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

Since the problem started is it: _____ About the same _____ Getting better _____ Getting worse

What have you done for this condition(s)? Was it of benefit?

What activities aggravate your condition(s)?

Is this condition interfering with your: work _____ sleep _____ daily routine _____ sports/exercise _____

Other _____

Are you unable to do certain activities that you would like to do because of this pain, illness, condition?
(i.e. sports, walk, pick up grandchildren, etc.) If so, what?

What lesson(s) have you taken home from your healing process to date?

Why are you here at this point in time?

Name of other Doctor's seen for this condition(s):

"Limited Scope" Chiropractor (Focuses mainly on neck and back pain) _____ / _____

"Wellness" Chiropractor (focuses on overall health as well as underlying cause of pain and health concerns) _____

Medical Dr. _____ / _____ Specialist _____ / _____

Other _____

II. GENERAL HEALTH HISTORY SECTION

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type _____ When _____

2. Type _____ When _____

3. Type _____ When _____

4. Type _____ When _____

Accidents and/or injuries: auto, work-related, or other (Especially those related to your present problems)

1. Type _____ When _____ Hospitalized ___ Yes ___ No

2. Type _____ When _____ Hospitalized ___ Yes ___ No

3. Type _____ When _____ Hospitalized ___ Yes ___ No

CURRENT MEDICINE(S)/SUPPLIMENTS:

Please list any medications you have taken in the past 2 months and why: (prescription and over-the-counter)

List any known allergies to have had to any medication

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

III. PAST HEALTH HISTORY:

Mark any of the following conditions you have had in the **past** with (√) or any **current** conditions with a (+)

General

- Dizziness
- Swelling
- Trouble concentrating
- Cold sweats
- Irregular sleep
- Spaciness
- Fatigue

Head/Neck

- Headaches
- Head feels too heavy
- Neck pain
- Teeth grinding/TMJ
- Grating in neck
- Tight shoulder muscles
- Pinched nerve

Back/Arms/Legs

- Mid-back pain
- Disc herniation
- Low back pain
- Leg/feet pain
- Arms/hand pain
- Pins/needles in hands/feet
- Cold hands/feet

Cardiovascular/Respiratory

- Chest pains
- Heart palpation
- Heart attacks
- High/low blood pressure
- High Cholesterol
- Asthma
- Shortness of breath

Women Only

- Menstrual cramps
- Menstrual irregularity
- Hot Flashes/Menopause
- Endometriosis/Cysts

Ears/Nose/Throat

- Thyroid trouble
- Ringing in ears
- Sinuses
- Re-current infections
- Allergies

Digestive

- Indigestion/gas
- Ulcers
- Irritable bowel
- Constipation/diarrhea
- Gallbladder trouble
- Liver trouble

Previous or Current Diagnosis

- Arthritis
- Cancer
- A.D.D./A.D.H. D
- Diabetes
- Anemia
- Fibromyalgia

Mental/Emotional

- Irritability
- Depression
- Anxiety
- Nerves & nervousness

Other (please explain) _____

Do you currently smoke tobacco of any kind? Yes Former Smoker Never Smoked

Because accumulation of stress affects our health and ability to heal please list your top two stresses you have ever had in each category:

1. Physical stress (falls, accidents, work postures, etc.)

- a. _____
- b. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

- a. _____
- b. _____

3. Psychological/Emotional stress (work, relationships, finances, self-esteem, etc.)

- a. _____
- b. _____

Questions From Video (All questions must be answered before your appointment or it will be rescheduled.)

Question 1: What system of the body controls everything including over all health? _____

Question 2: What are three types of stress? _____

Question 3: How do you know you have a subluxation? _____

Question 4: What services do you want? Adjustments Nutrition Lifestyle Education Other _____

Is there anything else which may help to better understand you which has not been discussed?



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TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept a practice member for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each practice member understands both the objective and the method that will be used to obtain it. This will prevent any confusion.

Adjustment: An adjustment is the specific application of forces to facilitate the body’s correction of subluxation. Our Chiropractic method of correction is by specific, gentle adjustments.

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

Subluxation: An impediment in the brain and nervous system 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 regulate and heal itself. Subluxations appear as the colored bars on the computer scans.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a 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 of the body’s innate wisdom. Our only method is specific adjusting to correct subluxations.

I, _____ have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

Signature

Date

I hereby authorize the release, use, or disclosure of my health information by Live Well Chiropractic for purposes of treatment, payment, or healthcare operations. I understand that I may revoke this authorization at any time in writing. This authorization will remain in effect unless otherwise stated by myself or LWC.
I understand that I may request a copy of the privacy policy of LWC.

Signature

Date

You may discuss my health information with the following people:
