living well CHIROPRACTIC
A FAMILY WELLNESS CENTER

Patient Information and History

Date:_____

1 PATIENT INFORMATION

Name:_____
(First, M.I., Last, Name called by)
Address:_____
_____
Birthday:_____ Age: _____ ☐ M ☐ F
SS#_____/____/_____ Occupation:_____
Employer:_____
Parents name (if a minor)_____
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Spouse's name: _____
# of children:____ Name(s)_____
How did you hear about us?_____

ACCIDENT INFORMATION

Is your condition due to an accident? ☐ No ☐ Yes Date:_____
Type of Accident ☐ Automobile ☐ Work ☐ Home ☐ Other
To whom have you reported the accident?
☐ Insurance ☐ Worker's Comp ☐ Employer ☐ Other
Attorney Name (if applicable)_____

2 INSURANCE

Who is responsible for this account? _____
Relationship to patient: _____
Insurance Company: _____
Insurance ID#: _____
Group/Claim#: _____
Is patient covered by additional insurance?
☐ Yes ☐ No
Insurance Company: _____
Subscriber# and name: _____
Birthdate: _____ Group #: _____

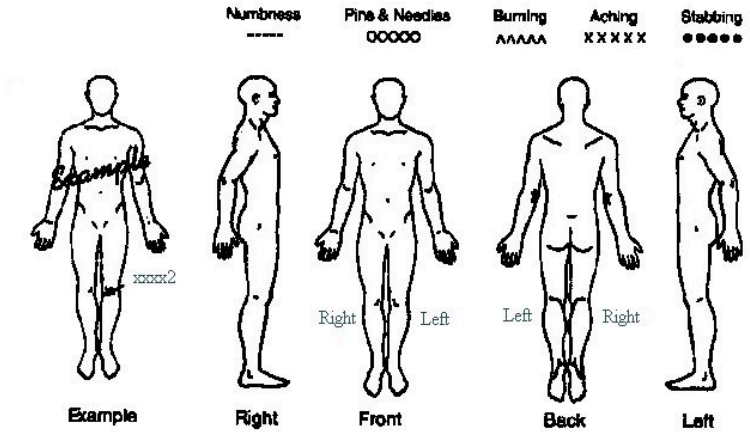
CONTACT INFORMATION

Home Phone _____ Cell _____
Work Phone_____ Email _____
Best way to reach you _____
IN CASE OF EMERGENCY CONTACT
Name _____ Relationship _____
Home Phone _____ Cell _____

3 PATIENT CONDITION

What is your major symptom/problem?_____
When did your symptoms begin?_____
Have you had this problem before?_____
Is your condition getting progressively worse? ☐ Yes ☐ No
Is this problem: ☐ constant ☐ comes and goes
How does it feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Aching ☐ Stiff ☐ Tingling ☐ Swelling
☐ Throbbing ☐ Stabbing ☐ Other_____
Circle below the severity of your pain on a scale of 0 to 10:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)
What makes your condition better?_____
What makes your condition worse?_____
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities/movements that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Driving ☐ Reading ☐ Getting up

PLEASE MARK WHERE IT HURTS



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HEALTH HISTORY

What other treatments have you had for this condition?

☐ Chiropractic ☐ Orthopedic ☐ Neurologist ☐ Physical Therapy ☐ Medication ☐ Surgery

Who is your medical doctor?_____ Office location: _____

Name of other doctors who have treated you for this condition: _____

Describe the other doctor's treatment for your condition: _____

Previous Chiropractic Care? ☐ No ☐ Yes Date: _____ ☐ Local ☐ Out of State: _____

Date of Last: Physical Exam: _____ Spinal Xray: _____ MRI: _____

Spinal Exam: _____ Dental Xray: _____ CT scan: _____

List any medications you are taking: _____

Vitamins/ Herbs/ Minerals: _____

FEMALES: Are you pregnant? ☐ Yes ☐ No Beginning of last menstrual cycle: _____

Check any of the following conditions you have had:

☐ Aids/HIV	☐ Epilepsy	☐ Neck pain
☐ Allergies	☐ Headaches	☐ Osteoporosis
☐ Anxiety/Depression	☐ Headaches-migraine	☐ Poor circulation
☐ Arm/Shoulder pain	☐ Heart Disease	☐ Prostate problems
☐ Arthritis	☐ Hemorrhoids	☐ Rheumatoid Arthritis
☐ Asthma	☐ Herniated disk	☐ Sciatica
☐ Bladder problems	☐ High blood pressure	☐ Shingles
☐ Cancer	☐ Insomnia	☐ Sinus infection
☐ Chronic fatigue	☐ Irregular cycle	☐ Stroke
☐ Deafness	☐ Kidney problems	☐ Thyroid problems
☐ Diabetes	☐ Leg pain	☐ TMJ
☐ Digestion problems	☐ Low back pain	☐ Venereal disease
☐ Earache	☐ Lyme's disease	☐ Vertigo/Dizziness
☐ Ear ringing		

Family history of autoimmune disorders? (Lupus, Rheumatoid, AS, MS, Myasthenia Gravis, DISH, etc.) _____

STRESSORS

		EXERCISE
☐ Smoking	Packs/Day: _____	☐ None
☐ Alcohol	Drinks/Week: _____	☐ Moderate
☐ Coffee/ Caffeine Drinks	Cups/Day: _____	☐ Daily
☐ High stress level	Reason: _____	☐ Heavy

Are you interested in learning about wellness and preventative care after we resolve your current complaint?

Explain:_____

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Have you had any:	**Description**	**Date**
Auto accidents	_____	_____
Surgeries	_____	_____
Broken bones	_____	_____
Falls/Head injuries	_____	_____

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AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Living Well Chiropractic LLC / John Slippy D.C. / Kevin Turner D.C. / Keith Yocum D.C., to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Signature Date Parent (if patient is a minor)