Welcome To Live Well Chiropractic

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(***Please Print***)

Name ________________________ Date _______EMail__________________
First MI Last
Address ____
City__________________ State___Zip ________________________
Social Security #__-__-___ Type of Work______________________
Name of Employer____
Business Address____
Sex: F M
Birth date__/_/__ Home phone #__________ Work phone#_________
Cell Phone___________ Do you prefer calls at: __Home __Work __Cell

Please circle one: Single Married Divorced Widowed Domestic Partner
Spouse/Partner's name_______________________________________
Number of children_____ Children's names & ages_________________
Spouse/Partner's Employer____________________________________
Emergency Contact:____
(Name) (Relation) (Phone Number)
Whom may we thank for referring you?___________________________

Current Health Condition

Purpose of this appointment:___________________________________

If this appointment is for anything other than to maintain health please fill out the following:
Other doctors seen for this condition? Y N Who? _________________
Type of treatment: _______________ Results: ____________________
When did this condition begin?___________________________________
Is condition related to: job home injury fall auto accident other:______
Date and time of accident:_____________________________________

Please list all drugs you currently take:___________________________
____
Please list all previous surgeries:________________________________

Previous Chiropractic Care? Y N List Doctor's name and date of last visit:
____

Please list any major accidents or falls including broken bones:
____

Health History

Hospitalizations(other than listed on previous page):__________________________

Below is a list of diseases that may seem unrelated to the purpose of your visit. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Please circle if you have ever had any of the following diseases:

Pneumonia	**Mumps**	**Influenza**	**Pleurisy**	**Rheumatic Fever**	**Smallpox**
Polio	**Chicken Pox**	**Arthritis**	**Epilepsy**	**Diabetes**	**Cancer**
Tuberculosis	**Anemia**	**Thyroid**	**HIV/AIDS**	**Heart Disease**	**Eczema**

Please check any of the following that you have experienced:

Musculo-skeletal
- __Low Back pain
- __Pain Between shoulders
- __Neck Pain
- __Arm Pain
- __Joint Pain/Stiffness
- __Walking Problems
- __Clicking Jaw
- __General Stiffness

Nervous System
- __Nervousness
- __Numbness
- __Paralysis
- __Dizziness
- __Forgetfulness
- __Depression
- __Fainting
- __Convulsions
- __Stress
- __Stroke

Cardiovascular
- __ Chest Pain
- __ Shortness of Breath
- __ Blood Sugar Problems
- __ Irregular Heart Beat
- __ Heart Problems
- __ Lung problems
- __ Varicose Veins
- __ Ankle Swelling

EENT
- __Visual Problems
- __Dental Problems
- __Sore Throat
- __Stuffed Nose

General
- __Fatigue
- __Allergies
- __Loss of sleep
- __Headaches

Genito-Urinary
- __ Bladder Trouble
- __ Painful/Excessive Urination
- __Discolored Urine

Gastrointestinal
- __Excessive Thirst
- __Frequent Nausea
- __Vomiting
- __Diarrhea
- __Constipation
- __Liver Problems
- __Gall Bladder Problems
- __Weight Trouble

Females Only
- __Menstrual Irregularity
- __Menstrual Cramps
- __Vaginal Pain/Infection
- __Breast Pain/Lumps

Are you pregnant? Y N
Date of Last Period: __________

Men Only
- __Breast pain/lumps
- __Prostate Problem
- __Sexual Dysfunction

Please let us know if any of your biological relatives suffer from health problems or if they are deceased as a result of a health problem.

Mother_________________ **Father**__________________ **Brother/s**_______________
Sister/s_________________ **Spouse/Partner**________________ **Child**____________________

Insurance Information

If you would like us to validate your insurance coverage please provide your insurance card and a photo ID so that we may make a copy and contact your insurance to see if chiropractic benefits are available for you. We will inform you of your insurance eligibility during your report. By signing this section you are giving us permission to check on your chiropractic benefits.

X____ **Date**______________