

**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 #: \_\_\_\_\_

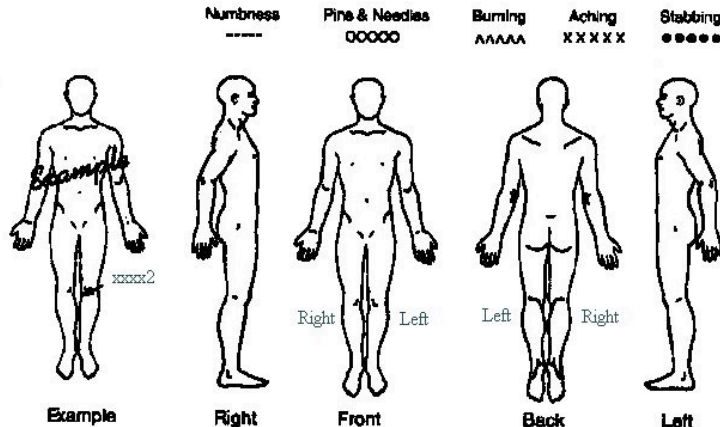
**CONTACT INFORMATION**

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**



# 4

## 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:

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

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

### STRESSORS

- Smoking  
 Alcohol  
 Coffee/ Caffeine Drinks  
 High stress level

Packs/Day: \_\_\_\_\_

Drinks/Week: \_\_\_\_\_

Cups/Day: \_\_\_\_\_

Reason: \_\_\_\_\_

### EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

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

Explain: \_\_\_\_\_

# 5

### Have you had any:

	Description	Date
Auto accidents	_____	_____
Surgeries	_____	_____
Broken bones	_____	_____
Falls/Head injuries	_____	_____

# 6

## 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)