Patient Confidential Information

Lifestyle CHIROPRACTIC on Front Street

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Hm Phone: _____Cell/Pgr:_____ Birth Date: _____ Age: _____ Sex: o M o F

Social Security #: _____ Driver's License #: _____

Business Employer: _____ Circle One: Married Single Widowed Divorced Separated

Business Phone: _____ Occupation: _____

Business Address: _____ E-mail: _____

Name of Spouse/Names and Ages of Children: _____

Whom may we thank for referring you to us? _____

Is your Condition: o Job Related o Auto Accident o Home Injury o Fall o Other: _____
Date of Accident: _____ Time of Accident: _____
Have you made a report of your accident to your employer? o Yes o No
Who is responsible for your bill? You and o Spouse o Worker's Comp o Auto Ins. o Medicare o Health Ins.
Insurance Co:_____ Group #:_____ ID#:_____

Symptoms

Reason for visit _____
When did you first notice the symptoms? _____
Is the condition getting progressively worse? _____
Where specifically is the problem(s) located? _____
Which activities are difficult to perform? o Sitting o Standing o Walking o Bending o Lying down o Other
Type of pain: o Sharp o Dull o Throbbing o Numbness o Aching
o Shooting o Burning o Tingling o Cramps o Stiffness
o Swelling o Other _____
Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _____
What treatment have you already received for your condition?
o Medication o Surgery o Physical Therapy o Other _____
Name and address of other doctor(s) who have treated you for your condition:

_____
_____

Daily Habits

What type of exercise do you perform on a daily basis? o None o Moderate o Heavy
What do your daily work habits include (Ex: sitting, standing, light or heavy labor, computer work)

_____
What vitamins do you currently take? _____
What kind of other supplements do you take (if any)? _____
Do you smoke? o Yes o No How much per day? _____
How much liquor do you consume on a weekly basis? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____
Please list all medications you are currently taking: _____
Allergies: _____

Health History

Check any of the following you have experienced within the past 6 months.

MUSCULO-SKELETAL
o Low Back Pain
o Pain Between Shoulders
o Neck Pain
o Arm Pain
o Joint Pain/ Stiffness
o Walking Problems
o Difficult Chewing/ Clicking Jaw
o General Stiffness

NERVOUS SYSTEM
o Nervous
o Numbness
o Paralysis
o Dizziness
o Forgetfulness
o Confusion/Depression
o Fainting
o Convulsions
o Cold/Tingling Extremities
o Stress

GENERAL
o Fatigue
o Allergies
o Loss of Sleep
o Fever
o Headaches

GASTRO-INTESTINAL
o Poor/Excessive Appetite
o Excessive Thirst
o Frequent Nausea
o Vomiting
o Diarrhea
o Constipation
o Hemorrhoids
o Liver Problems
o Gall Bladder Problems
o Weight Trouble
o Abdominal Cramps
o Gas/Bloating After Meals
o Heartburn
o Black/Bloody Stool
o Colitis

GENITO-URINARY
o Bladder Trouble
o Painful/Excessive Urination
o Discolored Urine

C-V-R
o Chest Pain
o Short Breath
o Blood Pressure Problems
o Irregular Heartbeat
o Heart Problems
o Lung Problems
o Varicose Veins
o Ankle Swelling
o Stroke

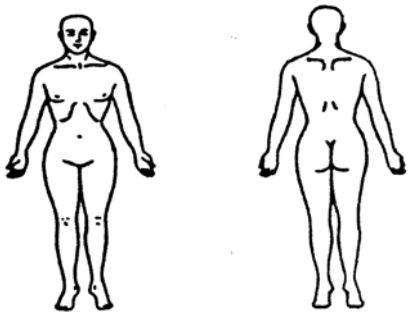
EENT
o Vision Problems
o Dental Problems
o Sore Throat
o Ear Aches
o Hearing Difficulty
o Stuffed Nose

MALE/FEMALE
o Menstrual Irregularity
o Menstrual Cramps
o Vaginal Pain/Infection
o Breast Pain/Lumps
o Prostate/Sexual Dysfunction
o Other Problems
o _____
o _____

FEMALES ONLY
When was your last period?
_____

Are you pregnant?
o Yes o No o Not Sure

FAMILY HISTORY
The following members have the same or similar problem as I do
o Mother
o Father
o Brother
o Sister
o Spouse
o Child



Please outline on the diagram the area of your discomfort.

Authorization

I certify that I have read and understand the above information to the best of my knowledge. I hereby authorize the Doctor to treat my condition as he/she deems appropriate through use of manipulation throughout my spine. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized and assigned to be paid directly to Lifestyle Chiropractic will be credited to my account on receipt. I authorize the use of this signature on all insurance submissions. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. I have read HIPAA Notice of Privacy Practice and understand my rights stated within the document.

X _____

SIGNATURE OF PATIENT (or parent if a minor) DATE