LivingWell CHIROPRACTIC

Patient Intake Questionnaire

Office Use Only
❑ Ecl. ❑ DrC.

Confidential Patient Information | Please tell us about you.

Today's Date ____ /____ / 20____ **How did you hear about us?** _____

First Name _____ Middle Initial _____ Last Name _____

Nick Name? _____ DOB ____ /____ /_____ Gender: ❑ Male ❑ Female

Marital Status _____ Spouse/Partner Name _____

LOCAL Address _____

_____

City _____ FL ZIP_____

OTHER Address? _____

_____

City _____ ST____ ZIP_____

Best Email (*print neatly on the line below*):

_____

Best Phone (_____) _____ - _____

❑ Mobile Phone ❑ Land Line

Emergency Contact _____

Relation to You _____

Best Phone (_____) _____ - _____

❑ Mobile Phone ❑ Land Line

Parent of How Many Children?_____ Pregnant? ❑ Yes ❑ No Grandparent of How Many Children?_____

Current or Former Occupation _____ Retired? ❑ Yes ❑ No

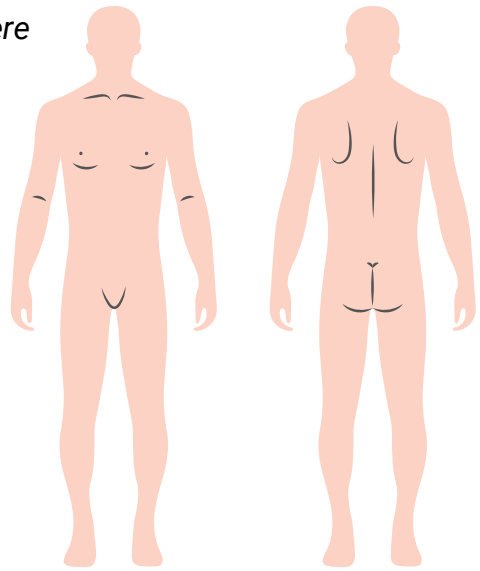
Confidential Health Information | Please tell us about your symptoms.

What is the reason for today's appointment? _____

_____

What is the cause of your symptoms? ❑ Car Accident ❑ Daily Living ❑ Injury from: _____

On the human figure diagram to the right, place a small x in any area/s where you typically experience any symptoms.



DESCRIBE THE FEELING OF YOUR SYMPTOMS:

❑ Numbness ❑ Dull Pain ❑ Nagging ❑ Shooting
❑ Tingling ❑ Sharp ❑ Aching ❑ Throbbing
❑ Stiffness ❑ Cramps ❑ Burning ❑ Stabbing

❑ Other (Please describe): _____

_____

DESCRIBE THE FREQUENCY OF YOUR SYMPTOMS:

❑ My Symptoms are constant. ❑ My Symptoms come and go.

IMPORTANT: Are you in pain right now? ❑ Yes ❑ No

Circle a number on the scale to represent your ***current*** pain:

Confidential Health Information | Please tell us about your condition.

DESCRIBE WHAT MAKES YOUR CONDITION WORSE OR BETTER + ITS IMPACT ON DAILY LIFE

What makes your condition ***worse***?

❑ Sitting ❑ Bending
❑ Standing ❑ Laying Down
❑ Walking ❑ Other_____

What makes your condition ***better***?

❑ Sitting ❑ Bending
❑ Standing ❑ Laying Down
❑ Walking ❑ Other_____

	DOES *NOT* IMPACT	SLIGHTLY IMPACTS	SEVERELY IMPACTS
Sitting	❑	❑	❑
Rising from Seat	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Bending Over	❑	❑	❑
Getting in/out of Car	❑	❑	❑
Driving Car	❑	❑	❑
Looking Over Shoulder	❑	❑	❑
Reaching Overhead	❑	❑	❑
Showering/Bathing	❑	❑	❑
Getting Dressed	❑	❑	❑
Caring for Family	❑	❑	❑

	DOES *NOT* IMPACT	SLIGHTLY IMPACTS	SEVERELY IMPACTS
Lifting Objects	❑	❑	❑
Household Chores	❑	❑	❑
Yardwork	❑	❑	❑
Grocery Shopping	❑	❑	❑
Work/Using Computer	❑	❑	❑
Concentrating	❑	❑	❑
Exercising	❑	❑	❑
Climbing Stairs	❑	❑	❑
Laying Down	❑	❑	❑
Love Life	❑	❑	❑
Falling Asleep	❑	❑	❑
Staying Asleep	❑	❑	❑

DESCRIBE ANYTHING YOU'VE ALREADY TRIED TO RELIEVE YOUR CONDITION

❑ Prescription Meds ❑ Over-the-counter Meds ❑ Massage ❑ Other:_____

Confidential Health Information | Please tell us about your lifestyle.

I engage in **EXERCISE**:	❑ Never	❑ Moderately	❑ Daily	❑ Heavily
This best describes my **WORK**:	❑ Sitting	❑ Standing	❑ Light Labor	❑ Heavy Labor
My daily **HABITS** include:	❑ Smoking	❑ Alcohol	❑ Caffeine	❑ High Stress

My **MEDICATIONS** include: _____

_____

INJURIES or SURGERIES? *Describe Below with Approximate Date/s*

Serious Falls _____
Head Injuries _____
Broken Bones _____
Dislocations _____
Surgeries _____

Acknowledgement of Truth and Receipt of Notice of Privacy Practices

*To the best of my ability, the information I have supplied is complete and truthful, with the intention of receiving care for my condition from LivingWell Chiropractic. I have not misrepresented the presence, severity, or cause of my health concern. I acknowledge that I was provided a copy of the **Notice of Privacy Practices**. I understand that this form will be placed in my patient chart and maintained for practice records.*

Patient's Full Name (*print*) _____ **Patient is:** ❑ Adult ❑ Minor Child

Legally Responsible Adult's Name (*print*) _____

Adult Signature _____ **Date** _____

Review of Systems and Medical History

Y	N	
❑	❑	**Constitutional** (e.g., weight loss, fatigue, night sweats) If yes, please specify: _____
❑	❑	**Eyes** (e.g., double vision, pain, floaters, flashes, dry eye, decreased vision, tearing, cataracts, glaucoma) If yes, please specify: _____
❑	❑	**Ears, Nose, Mouth, Throat** (e.g., hearing loss, sinus disease, sore throat, dentures) If yes, please specify: _____
❑	❑	**Cardiovascular** (e.g., chest pain, heart murmur, palpitations, heart attack, high blood pressure, hand/ankle swelling) If yes, please specify: _____
❑	❑	**Pacemaker/Defibrillator** If yes, please specify: _____
❑	❑	**Respiratory** (e.g., cough, wheezing, emphysema, asthma, difficulty breathing) If yes, please specify: _____
❑	❑	**Gastrointestinal** (e.g., stomach pain, liver problems, acid reflux, vomiting, diarrhea) If yes, please specify: _____
❑	❑	**Genitourinary** (e.g., urination difficulty, prostate disease, bladder problems, kidney dialysis) If yes, please specify: _____
❑	❑	**Integumentary** (e.g., skin rash, scarring, dermatitis/eczema, skin cancer) If yes, please specify: _____
❑	❑	**Neurological** (e.g., stroke, seizure, numbness, weakness, Alzheimer's, headaches, dizziness) If yes, please specify: _____
❑	❑	**Musculoskeletal** (e.g., arthritis, pain or swelling of joints, muscle pain, artificial joints) If yes, please specify: _____
❑	❑	**Hematologic/Lymphatic** (e.g., anemia, easy bruising, prolonged bleeding, use of blood thinners, blood disorders) If yes, please specify: _____
❑	❑	**Allergic/Immunologic/Infections** (e.g., hay fever, HIV, hepatitis) If yes, please specify: _____
❑	❑	**Endocrine** (e.g., diabetes, thyroid disease) If yes, please specify: _____
❑	❑	**Psychiatric** (e.g., anxiety, depression, mood swings, difficulty sleeping) If yes, please specify: _____

Authorization and Assignment

I authorize LivingWell Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.
I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.
I, the undersigned, do hereby appoint LivingWell Chiropractic the authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with LivingWell Chiropractic when said payments are due to services rendered on behalf of the undersigned by LivingWell Chiropractic.
I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Informed Consent

I hereby authorize physicians and staff at LivingWell Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.
I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of LivingWell Chiropractic responsible for any errors or omissions that I may have made in the completion of this form or additional supplemental forms.

- *Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.*
- *Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.*

Specific Risk Possibilities Associated with Chiropractic Care:

- **Soreness:** Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.
- **Soft Tissue Injury:** Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft-tissue injury.
- **Rib Injury:** Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.
- **Physical Therapy Burns:** Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.
- **Stroke:** Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.
- **Other Problems:** There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor. Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Signature: **Date:**

Witness: