Live Well Adjusted P.A.

7803 Afton Road | Woodbury, MN 55125 | 651-261-5020

HEALTH RECORD INTAKE FORM

ABOUT YOU

☐ ADULT ☐ MINOR 0-17	Today's Date

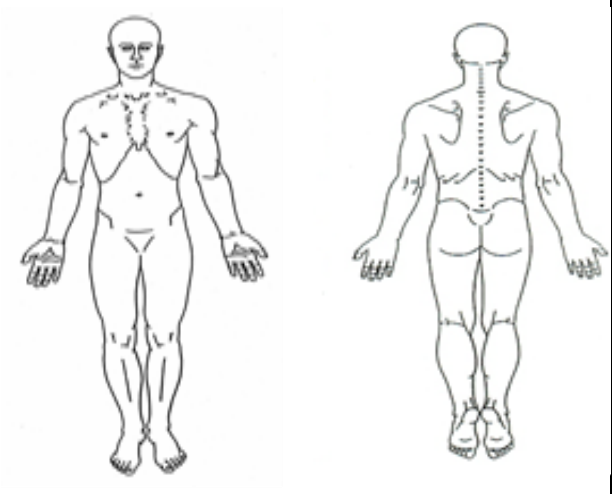
Full Name First Last MI	Nickname

Address Street City State Zip Code

Mobile Phone	Mobile Carrier(for sending text reminders)
Home Phone	Work Phone
Email	
DOB	Gender ☐ Male ☐ Female
Marital Status ☐ Single ☐ Married	Spouse Name
Employer	Position/Title
Emergency Contact	Emergency Contact Day Phone
How did you hear about us? ☐ Insurer Network ☐ Internet ☐ Sign ☐ Friend/Family	If referred by a friend or family member, who may we thank?

REASON FOR YOUR VISIT

Describe the primary concern for your visit today:
When did it start?
How did this start?
Has this condition/concern interfered with ☐ work ☐ sleep ☐ daily routine
Have you seen other doctors for this condition/concern ☐ Yes ☐ No
Since onset, has this condition ☐ gotten worse ☐ stayed the same

HEALTH CONDITIONS (Check all past/current disease/conditions)		**PAIN/CONCERN** (Place a "✓" on any area of pain/complaint)
☐ severe or frequent headaches	☐ dizziness	
☐ frequent neck pain	☐ Irritability	
☐ lower back problems	☐ ADHD/ADD	
☐ arthritis	☐ sleeping disorders	
☐ digestive problems	☐ vision problems	
☐ pain between shoulders	☐ diabetes	
☐ pain in arms/legs/hands	☐ shingles	
☐ numbness	☐ kidney problems	
☐ allergies	☐ hepatitis	
☐ sinus problems	☐ rheumatic fever	
☐ asthma/difficulty breathing	☐ ulcers/colitis	
☐ high blood pressure	☐ tuberculosis	
☐ low blood pressure	☐ congenital heart defect	
☐ thyroid problems	☐ pacemaker	
☐ constipation	☐ cancer	
☐ diarrhea	☐ chemotherapy/radiation	
☐ ear problems	☐ other _____	

List all surgeries:

List all past injuries/accidents:

Height	Weight	Blood Pressure

Females only - Are you pregnant, or could you be? ☐ YES ☐ NO

HEALTH HABITS

Have you been adjusted by a chiropractor? ☐ YES ☐ NO If yes, date of last visit? _____

Work activity ☐ sit often ☐ standing ☐ light labor ☐ heavy labor	Exercise program ☐ daily ___ days/week ☐ none Recreational activities _____
Do you smoke ☐ YES ☐ NO _____ packs/day	Do you drink alcohol ☐ YES ☐ NO _____drinks/week

Do you drink coffee/tea/soda ☐ YES ☐ NO ____ ounces/day

Vitamins ☐ fish oil ☐ multivitamin/minerals ☐ calcium/magnesium ☐ vitamin D ☐ vitamin C ☐ other _____

Medications ☐ cholesterol medications ☐ stimulants ☐ tranquilizers
☐ muscle relaxers ☐ insulin ☐ pain killers
☐ blood pressure medication ☐ aspirin ☐ Ibuprofen ☐ Tylenol
☐ Other _____ (Attach medication list, if needed)

AUTHORIZATIONS and CONSENTS (*Please read and initial each section)*

Initial _____	**Informed Consent for Chiropractic Treatment**. I consent to performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me, or on this individual, for whom I have the legal right to select and authorize health care services, by the licensed doctors of chiropractic, who now or in the future work at Live Well Adjusted, P.A. ("LWA"). If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify LWA. I have been given the opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes (CVA), and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which, will be based upon their knowledge and the facts given to them, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by initialing above I agree to the above –named procedures. I intend this consent form to cover the entire course of care of my present condition and for any future condition(s) for which I am seen for chiropractic care.
Initial _____	**Financial Responsibility**. I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for all bills incurred at LWA, whether or not paid by insurance.
Initial _____	**Insurance Claims**. I authorize the use of my signature below to allow the insurance companies to pay LWA and authorize the doctor to release all information necessary to secure payment of benefits.
Initial _____	**Missed appointments**. I understand that I may be charged $30 for any missed appointment that I schedule and do not cancel with at least two hours prior notice for doctor visits and 24 hours prior notice for massage therapy.
Initial _____	**HIPAA**. I am aware of LWA's Notice of Privacy Practices (a copy is available on our website at www.livewelladjustedchiro.com or a copy will be provided to you upon your request.

Access to Protected Health Information. I give permission to LWA's doctors, staff or designees to discuss my care or any information in my medical chart, including billing statements, with the following person(s). I understand that this written notification is effective immediately and can only be revoked or changed by myself in writing. This is in accordance with HIPAA regulations.

Designated Person: _____ Relationship _____

Date of Birth	**Patient Name (PRINT)**
Patient Signature ***(If applicable, Parent/Representative Signature and Relationship to Patient)***	**Date**