

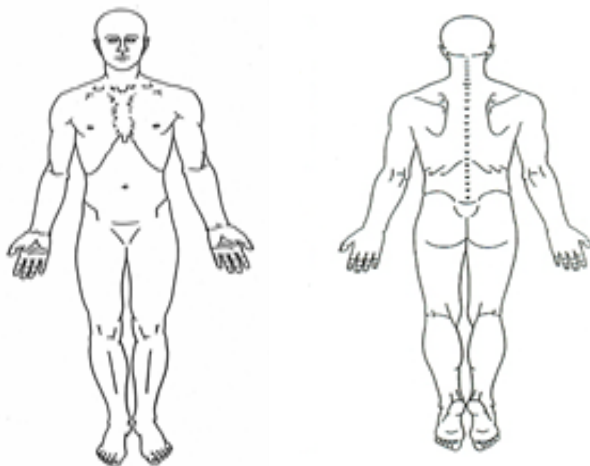
HEALTH RECORD INTAKE FORM

ABOUT YOU

Full Name	First	Last	MI	Nickname
Address	Street	City	State	Zip Code
Mobile Phone				
Home Phone			Work Phone	
Email				
Date of Birth:				
Preferred Pronouns - This helps us best understand how to address you: <input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They/Them			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married			Spouse Name	
Employer			Position/Title	
Emergency Contact			Emergency Contact Day Phone	
How did you hear about us? <input type="checkbox"/> Insurer Network <input type="checkbox"/> Internet <input type="checkbox"/> Sign <input type="checkbox"/> 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 <input type="checkbox"/> work <input type="checkbox"/> sleep <input type="checkbox"/> daily routine
Have you seen other doctors for this condition/concern <input type="checkbox"/> Yes <input type="checkbox"/> No
Since onset, has this condition <input type="checkbox"/> gotten worse <input type="checkbox"/> stayed the same

HEALTH CONDITIONS		PAIN/CONCERN
(Check all past/current disease/conditions)		(Place a "✓" on any area of pain/complaint)
<input type="checkbox"/> severe or frequent headaches <input type="checkbox"/> frequent neck pain <input type="checkbox"/> lower back problems <input type="checkbox"/> arthritis <input type="checkbox"/> digestive problems <input type="checkbox"/> pain between shoulders <input type="checkbox"/> pain in arms/legs/hands <input type="checkbox"/> numbness <input type="checkbox"/> allergies <input type="checkbox"/> sinus problems <input type="checkbox"/> asthma/difficulty breathing <input type="checkbox"/> high blood pressure <input type="checkbox"/> low blood pressure <input type="checkbox"/> thyroid problems <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> ear problems	<input type="checkbox"/> dizziness <input type="checkbox"/> Irritability <input type="checkbox"/> ADHD/ADD <input type="checkbox"/> sleeping disorders <input type="checkbox"/> vision problems <input type="checkbox"/> diabetes <input type="checkbox"/> shingles <input type="checkbox"/> kidney problems <input type="checkbox"/> hepatitis <input type="checkbox"/> rheumatic fever <input type="checkbox"/> ulcers/colitis <input type="checkbox"/> tuberculosis <input type="checkbox"/> congenital heart defect <input type="checkbox"/> pacemaker <input type="checkbox"/> cancer <input type="checkbox"/> chemotherapy/radiation <input type="checkbox"/> other _____	
List all surgeries:		
List all past injuries/accidents:		
Height	Weight	Blood Pressure
<i>Females only</i> - Are you pregnant, or could you be? <input type="checkbox"/> YES (Due Date: _____) <input type="checkbox"/> NO		

HEALTH HABITS

Have you been adjusted by a chiropractor? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, date of last visit? _____							
Work activity <input type="checkbox"/> sit often <input type="checkbox"/> standing <input type="checkbox"/> light labor <input type="checkbox"/> heavy labor		Exercise program <input type="checkbox"/> daily ____ days/week <input type="checkbox"/> none Recreational activities _____					
Do you smoke <input type="checkbox"/> YES <input type="checkbox"/> NO ____ packs/day		Do you drink alcohol <input type="checkbox"/> YES <input type="checkbox"/> NO ____ drinks/week					
Do you drink coffee/tea/soda <input type="checkbox"/> YES <input type="checkbox"/> NO ____ ounces/day							
Vitamins <input type="checkbox"/> fish oil <input type="checkbox"/> multivitamin/minerals <input type="checkbox"/> calcium/magnesium <input type="checkbox"/> vitamin D <input type="checkbox"/> vitamin C <input type="checkbox"/> other _____							
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; vertical-align: top;"> Medications <input type="checkbox"/> cholesterol medications <input type="checkbox"/> muscle relaxers <input type="checkbox"/> blood pressure medication <input type="checkbox"/> Other _____ </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> stimulants <input type="checkbox"/> insulin <input type="checkbox"/> aspirin </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> tranquilizers <input type="checkbox"/> pain killers <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Tylenol </td> <td style="width: 25%; vertical-align: bottom; text-align: right;"> (Attach medication list, if needed) </td> </tr> </table>				Medications <input type="checkbox"/> cholesterol medications <input type="checkbox"/> muscle relaxers <input type="checkbox"/> blood pressure medication <input type="checkbox"/> Other _____	<input type="checkbox"/> stimulants <input type="checkbox"/> insulin <input type="checkbox"/> aspirin	<input type="checkbox"/> tranquilizers <input type="checkbox"/> pain killers <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Tylenol	(Attach medication list, if needed)
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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. When applicable, 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 My 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 <i>(If applicable, Parent/Representative Signature and Relationship to Patient)</i>		Date