LIVEWELL CHIROPRACTIC NEW PATIENT INTAKE

Name:_____ Today's Date:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: ( )_____ Work: ( )_____ Cell: ( )_____

Email Address: _____

Male: _____ Female: _____ Birth Date: _____ Age: _____

Occupation: _____

Employer Name and Address: _____

Single: _____ Married: _____ Spouse's Name: _____

Childen (Name and Age): _____

Have you seen a Chiropractor before? Yes No If yes, when?_____

Whom may we thank for referring you to our office? _____

YOUR HEALTH HISTORY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problems.

- ☐ Headaches
- ☐ Pins and Needles in arms
- ☐ Dizziness
- ☐ Numbness in fingers
- ☐ Fatigue
- ☐ Sleeping problems
- ☐ Cold Sweats
- ☐ Mood Swings
- ☐ Pins and Needles in legs
- ☐ Loss of smell
- ☐ Buzzing in ears
- ☐ Numbness in toes
- ☐ Depression
- ☐ Neck Stiff
- ☐ Constipation
- ☐ Lights bother eyes
- ☐ Menstrual Pain
- ☐ Fainting
- ☐ Back Pain
- ☐ Ringing in ears
- ☐ Loss of taste
- ☐ Irritability
- ☐ Cold hands
- ☐ Fever
- ☐ Problem urinating
- ☐ Menstrual irregularity
- ☐ Neck Pain
- ☐ Loss of Balance
- ☐ Nervousness
- ☐ Stomach upset
- ☐ Tension
- ☐ Cold feet
- ☐ Hot flashes
- ☐ Heartburn
- ☐ Ulcers

Main Complaint:_____

List any medications you are taking: _____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ Total Score _____
PRINTED

_____ _____
Signature Date

Informed Consent:

CHIROPRACTIC: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the name of the patient below, for whom I am legally responsible) by the licensed doctors at LiveWell Chiropractic.
I understand and am informed that, as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment, including and not limited to fractures, disc injuries, strokes, dislocations, and sprain/strains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely upon the doctor to exercise judgment during the course of treatment which the doctor feels at the time, and based upon the facts known to him or her, is in my best interest. I understand that results are not guaranteed. I have read he above consent. I understand I have the opportunity to ask questions about its content and by signing below I agree to the above-mentioned procedures. I intend this consent form to cover my entire course of treatment for my present condition and for any future condition for which I seek treatment. I have received the Notice of Privacy Practices for protected health information. (*request a copy if needed).*

ACUPUNCTURE: Acupuncture is the insertion of a thin needle into the surface of the body. A patient may feel a slight pricking sensation near the needle. Patients usually report little or no pain during an acupuncture treatment.
Side Effects: The following side effects may occur and are not limited to the following: Some pain, minor bleeding, or bruising at the insertion location following treatment. (uncommon) Infections can happen but are very rare. Needle sickness (dizziness) or broken needles are almost unheard of. Much more common effects are a deep relaxation, pain relief, enhanced well-being, improved immunity and increased mental clarity.
Although no outcome of treatment can be guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the conditions of the patient.

MASSAGE: I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and or strokes may be modified to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Massage should not be performed under certain medical conditions. I affirm that I have stated all my known medical conditions and answered all the questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the licensed massage therapist reserves the right to refuse to perform massage on anyone whom she/he deems to have a condition for which massage is contraindicated.

Which this knowledge, I give my informed and voluntary consent to the above procedures:

PRINT NAME: _____ DATE:_____

Patient Signature:_____