Living Well
FAMILY CHIROPRACTIC & WELLNESS

Patient Information & History

Date: ______________________

You can complete this form by typing directly into the pdf, or print it to write responses. Bring the completed form to your appointment, or save and email to office@lwchiro.com

ABOUT YOU

Patient's Name ______________________

SS# ______________________ ☐ Male ☐ Female

Birthday ______________ Age ______________

Parent/Guardian (if a minor) ______________________

Address ______________________

____

City ______________ State ________ Zip ________

Primary Phone ______________ ☐ Cell ☐ Home

Work Phone ______________________

Email ______________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name ______________________

How many children ______________________

Employer ______________________

Occupation ______________________

Emergency Contact ______________________

Relationship ______________________

Phone 1 ______________________

Phone 2 ______________________

ABOUT YOUR CONDITION

Your primary symptom/issue ______________________

____

When did your symptoms begin? ______________________

Have you had this problem before? ☐ Yes ☐ No

Is it getting progressively worse? ☐ Yes ☐ No

Is it ☐ Constant or ☐ Periodic

How does it feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Aching

☐ Stiff ☐ Tingling ☐ Swelling ☐ Throbbing ☐ Stabbing

☐ Other ______________________

How severe is the pain?

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes it better? ______________________

What makes it worse? ______________________

Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

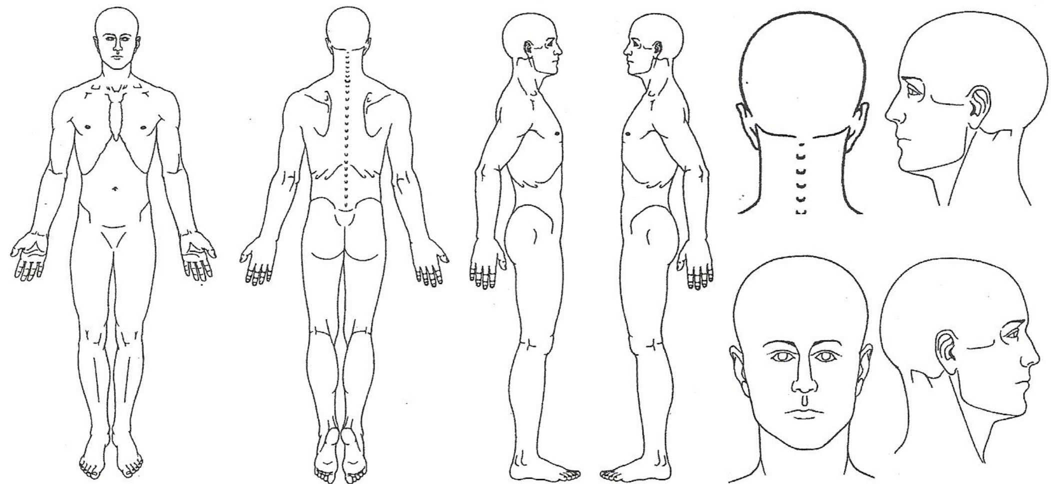
Does it make it painful to ☐ Sit ☐ Stand ☐ Walk ☐ Bend ☐ Lie Down

☐ Drive ☐ Read ☐ Get up

☐ Other ______________________

Indicate where you feel your pain:

If you're completing this form electronically, you can finish this portion in the office on your printed form.



ACCIDENT INFORMATION

Is your condition due to an accident? ☐ Yes ☐ No Accident date ______________________

Type: ☐ Automobile ☐ Work ☐ Home ☐ Other ______________________

To whom have you reported the accident? ☐ Insurance ☐ Worker's Comp ☐ Employer ☐ Other ______________________

Attorney Name (If applicable) ______________________

HEALTH HISTORY

What other treatments have you had for this condition?

☐ Chiropractic ☐ Orthopedic ☐ Neurologist ☐ Physical Therapy ☐ Medication ☐ Surgery ☐ Other ______

Other doctors who have treated you for this condition ______

Primary Physician ______ Office Location ______

Previous chiropractice care? ☐ Yes ☐ No Date______ ☐ Local ☐ Out of State ______

Date of last: Physical Exam ______Spinal Xray______MRI______

Spinal Exam______Dental Xray______CT scan______

Current medications: ______

Vitamins / Herbs / Minerals: ______

Check any of the following that you have had:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anxiety/Depression
- ☐ Arm/Shoulder Pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Deafness
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Earache
- ☐ Ear Ringing
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Herniated Disc
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Irregular Cycle
- ☐ Kidney Problems
- ☐ Leg Pain
- ☐ Low Back Pain
- ☐ Lyme's Disease
- ☐ Migraines
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Poor Circulation
- ☐ Prostate Problems
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Shingles
- ☐ Sinus Infection
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TMJ
- ☐ Venereal Disease
- ☐ Vertigo/Dizziness

Family History of Autoimmune disorders?
(Lupus, Rheumatoid, AS, MS, Myasthenia Gravis, DISH, etc.)

______

Stressors

☐ Smoking Packs/Day______

☐ Alcohol Drinks/Week______

☐ Coffee/Caffeine Drinks Cups/Day______

☐ High Stress Level Reason______

Exercise

☐ None ☐ Moderate ☐ Daily ☐ Heavy

Females: Are you pregnant? ☐ Yes ☐ No

Start of last menstrual cycle ______

Have you had any:	**Description**	**Date**
Auto Accidents		
Surgeries		
Broken Bones		
Falls/Head Injuries		

Our goal is helping you feel and move better as quickly as possible!

We also love providing continuing information about wellness and preventative care so that you understand your health and body on a deeper level. *Is this of interest to you?* ☐ That would be great! ☐ Not at this time

AUTHORIZATION

☐ All of the information provided on this form is true and accurate to the best of my knowledge.

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Living Well Chiropractic LLC & John Slippy D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize this signature on all insurance submissions.

______

Signature Date Parent (if patient is a minor)

Patient Report Release Form

I give my permission to release copies of my imaging studies and/or blood work reports with all medical notes to:

______________________________ as soon as possible.

Patient name: ____________________________________

Date of birth: ____________________________________

Patient Signature: _________________________________

Parent/Guardian signature: __________________________