Livin' Well Family Chiropractic Health History Form

Today's Date___________________________

Name____ Age __________ Date of Birth ____________________

Home Address_________________________________ City ___________________ State______ Zip _____________

Home phone (____) ____________________________ Cell Phone (____) ____________________________________

E-mail address____ Marital Status ❑ S ❑ M ❑ D ❑ W ❑ L/W

Occupation____________________________Employer ____

Emergency contact _______________________________ Phone (____) ________________Relation ____________

Names and Ages of Children ____

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

Have you ever received Chiropractic care? ☐**Y** ☐ **N** **Name of D.C.**_______________________________

What reasons do you have for visiting Livin' Well Family Chiropractic today?
Explain:____

FOR WOMAN

Are you pregnant? Y N Date of last menstrual period: _____________________________________
If x-rays are recommended, your signature is required (below) to indicate that you are **not pregnant**.
Signature: ____Date:_________________________________
If **pregnant**, Due Date: _____________ Name of OBGYN or Midwife ______________________________________

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the **major** traumas that you remember from your childhood up to the present.

Have you ever **hurt/injured** your spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? ❑ Y ❑ N
If yes, state ***type of injury and date:***

____

____

Have you ever **hurt, broken, fractured or sprained** any bones or joints? ❑ Y ❑ N
If yes, list ***body parts injured and dates:***

____

____

Have you ever been hospitalized? ❑ Y ❑ N
If yes, ***state reason and dates:*** ____

____

CHEMICAL STRESS

Do you **consume** any of the following presently?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):____

____

____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE

How do you grade your **physical health**? ❑ Good ❑ Fair ❑ Poor
How do you grade your **emotional/mental health**? ❑ Good ❑ Fair ❑ Poor
How do you rate your overall **"quality of life"**? ❑ Good ❑ Fair ❑ Poor
Do you **exercise** regularly? If yes, how often? ____
Do you take **supplements**? If yes, please list:____
Do you follow a **special dietary regime**? If yes, what? ____

Body Composition and Exercises:

1. Y N   Are you at your ideal weight? Current weight ________   If no, what is your desired weight _________
2. Y N   Are you interested in weight management?
3. Y N   Do you engage in cardiovascular exercise (e.g. aerobics, walking, swimming, etc.)?
   If yes, which activities ___________________________ Days per wek _______ Duration_________
4. Y N   Do you do any form of resistance exercises (lift weights) on a consistent basis? Days per week ____________
5. Y N   Do you ever experience pain after exercises? If yes, where ____________________ Type of pain? _______
6. Y N   Do you participate in any sports? If yes, which ones? ____

Commitment and Goals:

1. On a scale of 1 to 10, what level of stress do you experience daily? 1 2 3 4 5 6 7 8 9 10
2. On a scale of 1 to 10, what is your commitment to making a lifestyle improvement 1 2 3 4 5 6 7 8 9 10
3. What are your health goals for the next 6 months? ____

____

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)

- ❒ Relief of a symptom or problem
- ❒ Relief and prevention of a symptom or problem
- ❒ Healthier spine and nerve system
- ❒ Optimal health on all levels

FINANCIAL INFORMATION

Payment in full is expected on all **FIRST VISIT** services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon.

First visit includes: Consulation, Examination, x-ray, Spinal scan (adjustment not included)

INSURANCE

Due to the variations in insurance plans and chiropractic coverage, Livin' Well Family Chiropractic is a fee for service practice. This allows us to keep our fees low for individuals without insurance, without chiropractic coverage, or with limited chiropractic coverage. We keep our fees reasonable so that everyone, whether they have insurance or not can afford chiropractic care in this office. If you have any questions or concerns we are more than willing to discuss them with you. Our office is more than willing to print any receipts or provide any information you may need so that you can arrange reimbursement between you and your insurance provider if you wish to do so yourself, but payment is expected at the time of service and we will not bill your insurance provider.

If you have Medicare, our staff will need a copy of your insurance card.

PLEASE READ AND SIGN BELOW

If this is an Auto Accident or a Work-Related injury, please provide us with the following information:

Name of Auto Insurance Co: ____

Have you been treated elsewhere? ❑ Emergency Room ❑ Primary Care Doctor ❑ Other
What services were provided? ❑ MRI ❑ X-Rays ❑ Medication ❑ Therapy ❑ Other

The information I have provided on this case history form, is true and accurate to the best of my knowledge. I give Dr. Marley Smith and Dr. Heather Smith permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, chiropractic adjustment, and any other care that is determined to be clinically necessary and mutually agreed upon.

Signature____ Today's Date___________

Signature of Parent (for minor):____________________________ Today's Date___________

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS WHICH YOU HAVE NOW OR HAVE HAD IN THE PAST

N=NOW

P=PAST

N	P	**GENERAL**
__	__	Allergy
__	__	Chills
__	__	Convulsions
__	__	Depression
__	__	Dizziness
__	__	Fainting
__	__	Hernia
__	__	Headaches
__	__	Loss of sleep
__	__	Loss of weight
__	__	Nervousness
__	__	Tremors

N	P	**MUSCLE/JOINT**
__	__	Arthritis
__	__	Bursitis
__	__	Swollen joints
__	__	Low back pain
__	__	Neck pain/stiffness
__	__	Middle back pain

symptoms

N	P	**PAIN/NUMBNESS:**
__	__	Shoulders
__	__	Arms
__	__	Hands
__	__	Hips
__	__	Legs
__	__	Feet
__	__	Painful tailbone
__	__	Sciatica

N	P	**SKIN**
__	__	Bruise easily
__	__	Dryness
__	__	Hives
__	__	Itching
__	__	Skin lesions/rash

N	P	**G-I SYSTEM**
__	__	Belching/Gas
__	__	Colon problems
__	__	Constipation
__	__	Diarrhea
__	__	Difficult digestion
__	__	Gall Bladder issue
__	__	Hemorrhoids
__	__	Liver trouble
__	__	Nausea
__	__	Pain in stomach
__	__	Ulcers

N	P	**E.E.N.T.**
__	__	Colds
__	__	Crossed eyes
__	__	Deafness
__	__	Earaches
__	__	Ear noises
__	__	Enlarged glands
__	__	Vision flashes
__	__	Eye pain
__	__	Hoarseness
__	__	Nose bleeds
__	__	Sinus infections
__	__	Sore throat

N	P	**HEART**
__	__	Plaque in arteries
__	__	High blood pressure
__	__	Low blood pressure
__	__	Chest pain
__	__	Cold hands/feet
__	__	Rapid heart beat
__	__	Slow heart beat
__	__	Ankle swelling
__	__	Varicose veins

N	P	**LUNGS**
__	__	Chest pain
__	__	Chronic cough
__	__	Difficult breathing
__	__	Spitting up blood
__	__	Phlegm
__	__	Wheezing

N	P	**GENITO-URINARY**
__	__	Bed wetting
__	__	Blood in urine
__	__	Frequent urination
__	__	Painful urination
__	__	Prostate trouble

N	P	**WOMEN ONLY**
__	__	Cramps
__	__	Excessive flow
__	__	Hot flashes
__	__	Irregular cycle
__	__	Lumps in breast
__	__	Menopause
__	__	Painful menses
__	__	Vaginal discharge
__	__	Miscarriage

Are you pregnant now?

YES___ NO___

Please leave any additional comments here: ____

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Thank you for choosing Livin' Well Family Chiropractic.

We look forward to helping you reach your full potential.