New Patient Intake Form

Patient Information:

*First Name_____ Middle_____ Last_____ *Please select gender: M F

*Date of Birth _____ *Email: _____

*Home Address _____*City _____*State _____ *Zip _____

*Primary Number: Cell/Work/Home: _____ Secondary Number: Cell/Work/Home: _____

Marital Status: Single Married Divorced Widowed Other

How many children_____ Number of pregnancies (women)_____ How many still reside with you: _____

Emergency Contact: Name_____ Phone number: _____ Relationship: _____

Employment: Employer_____ Job Title and duties: _____

Insurance: Please provide a copy of your insurance card for verification of benefits. If Auto or work injury, notify us immediately.

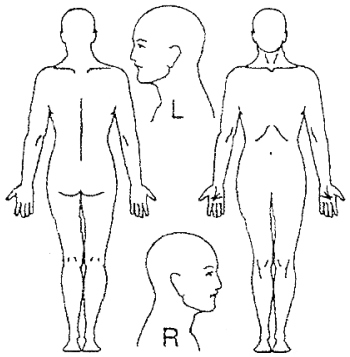
If Work Injury: Supervisor_____ Address_____ Phone # _____

Chiropractic Experiences:

Have you seen a Chiropractor previously? Y N For what condition? _____ Last Treatment Date _____

Whom may we thank for referring you to our office? _____ or How did you find us? _____

Current Symptoms Please draw your symptoms location on the chart below:



Purpose for visit: Acute(recent) condition, Chronic (>3 months) condition, Acute Exacerbation of a Chronic Condition, Maintenance treatment, Wellness/Prevention, Other_____

If due to an injury: Date injury occurred_____ Type of Injury: Auto related, Work related, Other trauma: _____

Please mark the level of your pain where 10 is the worse pain imaginable:

At it's Worse: (1 2 3 4 5 6 7 8 9 10) Best: (1 2 3 4 5 6 7 8 9 10) Average: (1 2 3 4 5 6 7 8 9 10)

Frequency of symptoms: constant (100%) frequent (75%) intermittent (50%) occasional (25%)

Please circle activities which aggravate your pain:

None	Repetitive motions	Child or pet care	Twisting
Almost any movement	Climbing stairs	Squatting	Grocery shopping
Athletic activity/exercise	Resting	Driving	Walking
Lying down	Computer use	Standing	Household chores
Bathing	Running	Eating	Working
Pulling	Concentrating	Stress	Lifting
Bending	Self-care (dressing,	Falling or staying asleep	Yard work
Pushing	bathing, etc.)	Stretching	Looking over shoulder
Reaching	Cooking	Getting in or out of car	Love life
Reading	Coughing and/or sneezing	Getting out of bed	OTHER_____
Changing positions	Sitting	Turning	

Has your injury caused loss of work? Y N If so, last date worked_____

Have you sought professional help for this injury? Y N Who did you see or where did you go? _____

What was the treatment: None, Acupuncture, Occupational therapy, Chiropractic care, Osteopathic medicine, Over-the-counter drugs, Prescribed medications, Homeopathic treatments, Physical therapy, Hypnosis, Injection therapy, Psychotherapy, Surgery, other Medical care, Nutritional supplements, OTHER:_____

Were x-rays taken? Y N If yes, where _____ Has this/similar injury occurred before? Y N When?_____

Personal Health:

Primary Care Physician: _____ Clinic Name: _____

Please list all hospitalizations and surgeries _____

_____

Please list all medication taken or prescribed in the last 12 months including antibiotics_____

_____

Please list all vitamins, herbs or supplements Currently Taking _____

Previously Taken _____

Do you experience allergies or other reactions? Y N If yes, to what? _____

Please mark any applicable food preferences or restrictions: none, vegan, vegetarian, gluten free, dairy free, other_____

Have you chronically or do you currently consume alcohol? Y N If yes, how often? Daily, weekly, socially, # of years____

Have you previously or do you currently smoke? Y N If yes, how often? _____ Packs/day (< ¼, ½, ¾, 1, 1 ½, 2, >2)

How many 8 oz. glasses of water do you drink on an average day? _____

Mark the type of water you normally drink: Tap Spring Distilled Filtered Purified Bottled Other_____

Mark any other beverages you consume regularly: Milk Juice Coffee Tea Herb Tea Soda Energy Drinks Other_____

What type of exercise do you participate in: Running Walking Lifting Organized Sports Biking Aerobic Class Swimming Other_____ Duration: _____ minutes/day

How often do you exercise a week: None Occasionally (1-2 weekly) Frequently (3-4 weekly) Regularly (5 or more/week)

How many servings of fresh/frozen fruit/vegetable, raw/cooked do you eat daily (1/2 cup dense or 1 cup loose = 1 serv):____

Are you getting daily restful sleep? Y N If not, please underline reason: Can't fall asleep, Wake up frequently,

Pain prevents sleep, Other_____ How many hours of quality sleep/night do you get on average? _____

Please underline any digestive or elimination concerns: Bloating Acid Reflux Diarrhea/Constipation Bleeding Hemorrhoids

Other Pain_____

How many meals do you eat daily? _____ How many bowel movements do average per week? _____

Please mark any dietary challenges you are currently experiencing (food cravings/addictions): Fried, Sugar, Salt, Dairy,

Caffeine Other_____

How often during the week do you make the following purchases?

Pre-Packaged Foods 1 2 3 4 5 6 7 8 9 + Restaurant/Fast Food 1 2 3 4 5 6 7 8 9 +

Junk food/Snacks 1 2 3 4 5 6 7 8 9 + Sweetened beverages 1 2 3 4 5 6 7 8 9 +

What is your average daily stress level: High Moderate Low

Please mark methods you use to manage your stress: Exercise Meditation/Prayer Reading Yoga/Other class Eating

Counseling Other_____

For Women Only:

Are you currently pregnant? Y N Date of last menstrual cycle? _____

Are you currently using birth control? Y N If yes, which one_____

Do you experience any of the following: Menstrual Pain, Heavy Bleeding, Irregular cycles, Polyps/cysts/fibroids, Other____

Do you experience pre-menopause or menopause symptoms? Y N

Are you currently using Hormone Replacement Therapy? Y N

Health History Problems/Concerns:

Please mark the following symptoms if you currently experience or occasionally experience:

Headaches,	Ringing/Buzzing in Ears	Head Feels Heavy	Varicose Veins
Neck Pain/Stiffness	Sleeping Problems	Loss of Smell/Taste	Hives/Allergy Rash
Mid Back Pain	Loss of Memory	Numbness/Weak	Gout
Low Back Pain	Stomach Pain/Upset	Legs/Feet	Eczema
Jaw Pain	Stomach Shortness of	Numbness/Weak	Bruise Easily
Fatigue	Breath Nervousness/	Arms/Hands	Blood in Urine
Tension	Anxiety Chest Pain	Pins & Needles in	Blood in Stool
Forgetfulness	Difficulty Concentrating	Arms/Hands	Painful Urination
Depression	Dizziness/Loss of Balance	Pins & Needles in	Bed Wetting
Allergy_____	Nausea/Vomiting	Legs/Feet	Kidney Infection
Asthma	Eyes Sensitive to light	Shoulder/Arm/Wrist Pain	Pace Maker
Restlessness	Sinus Pain	Hip/Leg/Knee/Ankle Pain	Stroke
Night Sweats	Ear Aches/Infection	Muscle Cramps	Other_____
Fainting	Fluid Retention	Hemorrhoids	

Have you or a close blood family member been diagnosed with any of the following: Osteoporosis, Heart Disease, Vascular Disorder, Diabetes, Inflammatory Disease, Arthritis/Joint Disease, Genetic Disease, Scoliosis, Infectious Disease Mental Illness, Cancer_____, Other_____

I certify that the above information is correct to the best of my knowledge.

Patient/Guardian Signature: _____ Date: ___/___/____

LEGAL ASSIGNMENT and MEDICAL RELEASE: In considering the amount of medical expenses to be incurred, I, the undersigned, may have insurance and/or employee health care benefits coverage and hereby assign and convey directly to Live Well Chiropractic (LWC) all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I authorize the release of any information including diagnosis and chart records of any evaluation and treatment rendered to me during the period of such care to other health practitioners who I have seen or plan to see for such procedures/treatment. CLINIC ACCOUNT POLICY: I understand that payment for services is expected at the time rendered and may be paid by cash, check, debit or credit card. Pre-payment or payment at the time of service is eligible for a non-billing, book-keeping savings. If I have insurance that pays for my care, LWC will be glad to bill for me. I will be responsible for all deductibles and/or co-payments. If I am experiencing financial hardship and need to make special payment arrangements, I can request assistance from LWC staff. Information received from the insurance company through verification of benefits IS NOT A GUARANTEE OF BENEFITS. LWC will strive to collect accurate information from my insurance. It happens, however, that insurance companies make mistakes. Occasionally LWC is informed that Insurance will cover procedures, but when billed, they will not pay them. LWC will inform me of any balance due. I am responsible for all charges incurred in this office. All contractual discounts will be applied when applicable. If I have a personal injury (auto accident or work comp) account, LWC will bill my insurance company and services will likely be covered at 100%. However if LWC is unable to collect all charges billed, I will be responsible for the remaining balance. I have read, understand and agree to the Clinic Account Policy stated above. That if this account is sent to collections, I agree that in addition to any amount left owing, I will be responsible for interest at the rate of 18% annually on any past due balance more than 60 days past due, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to 40% of the past due balance. This assignment will remain in effect for current and all future services rendered to me by LWC until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read, agree to, and fully understand my financial agreement. SCHEDULING PROCEDURES: All cancellations and rescheduled appointments are expected to give a 24-hour notice. Missed appointments, or those cancelled within 24 hours of the scheduled appointment time, may be charged a missed appointment fee. My appointment time is reserved exclusively for me. I will kindly be considerate of others - if I miss my appointment or cancel at the last minute, LWC will be unable to care for another patient in my place. Emergencies happen and schedules may need to be modified. I understand that LWC will respect my time and will avoid "double booking" my appointment to avoid time loss. Thus I agree to arrive on time for my appointment. If I think that I may potentially be late for my appointment, I will contact LWC as soon as possible so that LWC may advise me if my late arrival may still be accommodated. In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, I agree to pay for the billing code 99059(missed appointment fee) which is $35.00. DISCLOSURE AND CONSENT: I have rights as a patient to be informed about my condition and the recommended procedures, tests and treatment that I may receive by any staff member of LWC. This information is so that I may make an informed decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is simply an effort to make me better informed so that I may give or withhold my consent. I now hereby request and consent to the performance of examination, chiropractic adjustment and other procedures, including various modes of physical therapy and/or diagnostic tests including x-rays, on me (or the patient named below, for whom I am legally responsible) by Brian Tolman DC, and/or other licensed doctors of chiropractic or those working at the clinic who now or in the future treat me while employed by, working with, or serving as a substitute for Dr. Tolman. I understand I will have the opportunity to discuss with Dr. Tolman, or anyone whom may be assisting or replacing Dr. Tolman, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to examination and treatment including, but not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious side effects are rare but will be made known at my request. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the recommended treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from LWC.

To be completed by the patient

_____
Print Name

_____
Signature of Patient

_____
Date Signed

OR

To be completed by the patient's representative, if necessary for when the patient is a minor or physically/legally incapacitated:

_____
Print Name of Patient

_____ as: _____
Print Name of Patient's Representative Relation to Patient

_____ _____
Signature of Patient's Representative Date Signed