

— CONFIDENTIAL PATIENT INFORMATION

Welcome to our office

Please complete all questions.

Date _____

ID # _____

Office use

Name _____ Called name _____

Age _____ Sex ☐ M ☐ F Birthdate _____ Social Security # _____

Address _____ City / State / Zip _____

Cell phone _____ Home phone _____ Email address _____

Marital status ☐ S ☐ M ☐ D ☐ W Spouse's name _____

Emergency contact name _____ Phone _____

Children's names / ages _____

How did you hear about our office? _____

■ Important health information

I am not experiencing symptoms. I am primarily interested in Wellness Care. ☐ Yes ☐ No

What health challenges are occurring? _____ When did it begin? _____

Is it related to: ☐ Auto accident ☐ Work injury ☐ Personal injury ☐ None of these

Is the condition getting progressively worse? ☐ Yes ☐ No Constant? ☐ Yes ☐ No

Comes and goes? ☐ Yes ☐ No Height _____ Weight _____

Is the condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other _____

Have you previously had chiropractic care? ☐ Yes ☐ No When? _____

List all medications you are currently taking: _____

List all supplements you are currently taking: _____

List any surgeries / illnesses you have had: _____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, what type? _____

Is there a chance you may be pregnant? ☐ Yes ☐ No Date of last menstrual period _____

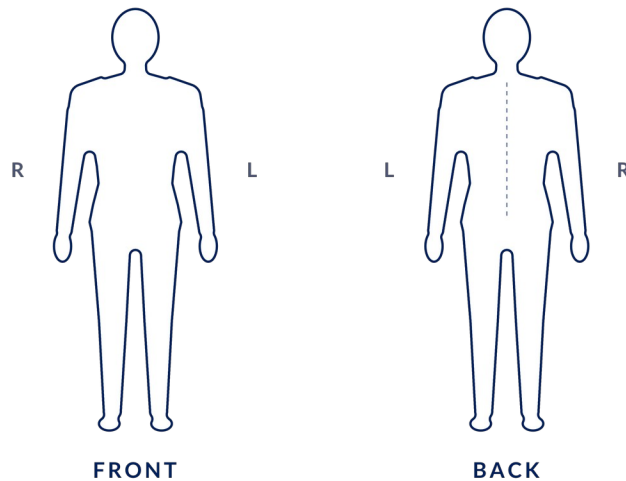
Please continue to the next page →

▪ **Do you now or have you ever suffered from (check all that apply):**

☐ Low back pain	☐ Headaches	☐ Ringing in ears	☐ Arthritis
☐ Mid back pain	☐ Gas/bloating	☐ Heart disease	☐ Scoliosis
☐ Neck pain	☐ Blood pressure high/low	☐ Chest pain	☐ Skin rashes
☐ Shoulder pain	☐ Ear aches	☐ Heart palpitations	☐ Fainting
☐ Pain or clicking jaw	☐ Elimination problems	☐ Shortness of breath	☐ Seizures
☐ Arm/leg pain	☐ Fatigue	☐ Blood clots	☐ Depression
☐ Numbness/tingling	☐ Loss of sleep	☐ Swelling	☐ Memory loss
☐ Digestive disorders	☐ Menstrual problems	☐ Heartburn	☐ Emotional stress
☐ Allergies	☐ Weight loss or gain	☐ Urinary urgency	☐ Thyroid condition
☐ Sinus trouble	☐ Vision changes	☐ Blood in urine	☐ Heat/cold intolerance
☐ Dizziness	☐ Glaucoma	☐ Incontinence	☐ Vasectomy/hysterectomy
☐ Asthma	☐ Cataracts	☐ Joint redness/swelling	☐ Other: _____

Do you have a family history of disease? Please list here: _____

▪ **Please mark all problem areas on the figures**



Please continue to the next page →

▪ Financial information

Do you have health insurance? ☐ Yes ☐ No With whom? _____

If yes, what is your relationship to the insured? ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If the insured is someone other than yourself, please complete the information below.

Insured's full name _____ Insured's date of birth _____

Financial responsibility: I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Lifepointe Chiropractic Center will prepare any necessary reports and forms to assist me in making collections from the insurance company. **HOWEVER, I clearly understand and agree that I am personally responsible for any payment.**

▪ Consent for treatment / terms of acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column that interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. Our chiropractic method of correction is specific adjustments of the spine. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, the undersigned, a patient in this office, hereby authorize Lifepointe Chiropractic Center to administer treatment as necessary, if needed, within the lawful scope of chiropractic. I also certify that no guarantee or assurance has been made to the results that may be obtained. I have read and fully understand the above statements, and accept chiropractic care on this basis.

Consent for a minor (if applicable): I, the undersigned, hereby authorize Lifepointe Chiropractic Center to administer treatment as necessary, if needed, within the lawful scope of Chiropractic to my child.

Name of child _____

▪ Notice of privacy practices

I understand the posted "Notice of Privacy Practices for Protected Health Information" describing how my medical information may be used and disclosed, and how I can get access to this information. (A copy of this document is available to me at any time.)

The above information is true and accurate to the best of my knowledge, and I understand and agree to the statements above.

Patient / guardian signature

Date