Live Well Chiropractic

New Patient Information

PLEASE PRINT

Name_____Social Security# _____

Address_____City_____State_____Zip_____

Date of Birth_____ Age_____ Gender: Male / Female

Marital Status: S M D W

Number of Children and Ages:_____

Home Phone_____Cell Phone_____Work Phone_____

Email address_____

Work Address_____City_____State_____Zip_____

Employer_____Occupation_____

Have you ever received Chiropractic care before? Yes/No **When?** _____

How long did your receive Chiropractic care? _____

How did you hear about us?
Please check all that applies

__Referral (Who) _____

__Spinal Screening (Where)

__Yellow Pages

__Sign (location)

__Internet (Website)

__Insurance Directory

__Magazine

__Primary Doctor

__Other

Loss of Wellness (Birth-Age 5)

1. During your birth

Yes	No	Was the delivery long?
Yes	No	Was the delivery difficult?
Yes	No	Forceps?
Yes	No	Caesarean?
Yes	No	Breach/cephalic?
Yes	No	Home birth?
Yes	No	Hospital birth?
Yes	No	Mother given drugs during delivery?
Yes	No	Was labor induced?

2. Your Growth and Development

Yes	No	Were you breastfed?
Yes	No	Childhood Sicknesses?
		If yes, explain: _____
Yes	No	Accidents?
		If yes, explain:_____
Yes	No	Did you fall while learning to walk?
Yes	No	Picked on by siblings?
Yes	No	Did you ever fall down stairs?
Yes	No	Were you ever yanked by your arm?
Yes	No	Did you have other traumas?
		If yes, explain:_____

Loss of Wellness (Age 5- Present)

Yes	No	Did/do you smoke?
Yes	No	Did/do you drink alcohol?
Yes	No	Diet (Do you eat healthy foods?)
Yes	No	Have you ever been in accidents?
		If yes, explain:_____

Yes	No	Have you had surgery and organs removed/replaced?
		If yes, list:_____
Yes	No	Drugs? (Prescriptive and non-prescriptive)
		If yes, list:)_____
Yes	No	Teeth problems?
Yes	No	Eye problems?
Yes	No	Hearing problems?
Yes	No	Exercise regularly?
Yes	No	Sleeping habits (nightmares)?
Yes	No	Did/do you have occupational stress?
Yes	No	Physical stress?
Yes	No	Mental stress?
Yes	No	Hobbies/sports injuries
Yes	No	Other traumas or problems
		If yes, explain:_____

Current Complaint:

Major complaint:_____

Pain/problem started when? _____

Are you symptoms constant? Yes/No or does it come and go? Yes/No
Have you had a similar condition in the past? Yes/No If yes when? _____

Pains are sharp? Yes/No or dull ache? Yes/No
What have you done for the problem? _____
Is the condition getting worse? Yes/No
Is the condition worse during certain times of the day? Yes/No If so, when? _____
Is this condition interfering with (circle those that apply): Work? Sleep? Daily Routine?
Other:_____
Other doctors seen for this condition:_____

Medical History:

What other health problems do you have? _____

Have you ever been diagnosed with cancer? _____

Have you been involved in an auto accident? Yes/No When? _____

Family history: Father's Side:_____

Mother's Side:_____

Primary Doctor Information:

Name: _____Phone Number_____

Address_____City_____State_____Zip_____

Date of last physical_____

Insurance Information:

Insurance Type: _____ Insurance ID number: _____

Primary Policy Holder's Name: _____ Policy Holder's Birth Date_____

*Any X-Rays taken at this office will remain the property of this office; if needed they may be borrowed for a specified period of time.

*I authorize Dr. Kemp to release information to my insurance company for payment. I authorize release to Dr. Kemp from other facilities regarding treatment. The above statements are true to the best of my knowledge.

*****PLEASE GIVE YOUR INSURANCE CARD TO RECEPTIONIST*****

Don't Miss Out!!

Most of our patients bring in their children to get adjusted. If you would like to have your children or spouse evaluated, check the box below and they can each receive a complimentary examination and x-rays (if necessary) if scheduled within 2 weeks of your starting care. This exam is no cost to you and does not obligate them to receive future care. We have several convenient and affordable family payment plans options should family members decide to receive care

☐ *I would like my family members evaluated in the next two weeks.*

Patient Signature_____Date_____

HIPPA Acknowledgement Sheet

Acknowledgement of Receipt of notice of Privacy Practices for Protected Health Information

I acknowledge that I have received Live Well Chiropractic's Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient: _____
Print Name

_____
Signature of patient/Personal Representative

Do you know what an advance directive is?

Advance directives are means for you to tell your health care givers about the care you wish to receive or not receive should you ever become unable to tell them of you wishes, There are two forms of advance directives, The first is a Living Will. The other is know as a "durable power of attorney for health decisions," or may also be called "durable appointment of a surrogate health care decision."Please discuss you advance directive choices with you Primary Care Physician.

Patient Signature:_____ Date: _____

Informed Consent For Evaluation/Diagnosis/Care/Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the chiropractor named below, including those working at the clinic or office listed below or any other office or clinic associated with Live Well Chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 upon the facts then known, and is in my best interest. Alternative treatments may include: medication, surgery, or Physical Therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, your condition could get worse, remain the same, or improve.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition. Any new condition other than what I am being treated for will be explained to me and a new consent will be signed.

Print Name of Patient: _____

_____

Patients Signature Date:

_____

Signature of Patient's Representative Date:
Relationship to Patient: Parent/ Guardian /Other:

(To be completed by patient's representative, if patient is a minor or is physically or mentally incapacitated).

_____

Doctor's Signature Date