

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____ MALE ___ FEMALE
 Address _____ City _____ State _____ Zip _____
 Email _____ Phone: HM _____ WK _____ Cell _____
 Best Number To Reach You ___ HM ___ WK ___ CELL _____ Birth Date _____ Age _____ # Children _____
 ___ Married ___ Single ___ Divorced ___ Widowed _____ Emergency Contact _____ Tel _____
 SS# _____ Employer _____ Occupation _____
 Do you have insurance that may contribute to your care? ___ Y ___ N Are you the Primary Insured (main person on your insurance) ___ Y ___ N
 If you are not the Primary Insured, please provide the **Name and Birthday of Primary Insured** _____
 REFERRED BY ___ Met the Doctor ___ Website ___ Online Search - please list keywords used to find us _____
 ___ Sign/Location ___ Newspaper ___ Other _____
 Existing Patient _____ Medical Doctor _____ Attorney _____

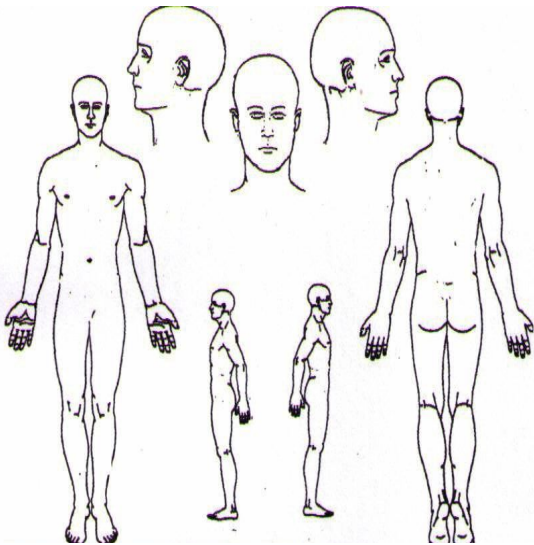
IF YOU NEED MORE ROOM TO ANSWER ANY QUESTION, PLEASE USE THE BACK OF THIS FORM.

What is your major complaint? (include Left, Right, or Bilateral) _____

Does it radiate anywhere? ___ Y ___ N If yes, where? _____
 How long have you had this complaint? _____ days / weeks / months / years Have you had this or a similar condition in the past? ___ Y ___ N
 Is this condition progressively getting worse? ___ Y ___ N ___ Staying the same Is it: ___ Constant ___ Frequent ___ Comes and Goes
 Circle all that apply: Achy, Dull, Throbbing, Crushing, Sharp, Severe, Stabbing, Burning, Other _____
 With 0 = no pain, and 10 = severe, at its best, my pain is a 0 1 2 3 4 5 6 7 8 9 10 - At its worst, my pain is a 0 1 2 3 4 5 6 7 8 9 10
 CIRCLE: This is a NEW / OLD injury and WAS / WAS NOT treated before. If treated before, what was done? _____
 We attempt to update your other health care providers regarding your condition unless you specifically request that we do not.
 Name and Clinic of your other Doctor(s) _____
 Have you ever had Chiropractic care before? ___ Y ___ N Date of last visit _____ Other complaints? (If you need more space, please write on the back of this form): _____

Please mark each area of pain / complaint with a:
If Left or Right Please circle L or R

Please mark each condition with a C" for Current, and a P" for Past.



- | | | |
|----------------------------------|--|------------------------|
| _____ Neck Problems | _____ Sore Muscles | _____ Allergies |
| _____ Shoulder Problems- L or R | _____ Muscle Cramps | _____ Hay Fever |
| _____ Arm Problems L or R | _____ Broken Bones | _____ Asthma |
| _____ Numbness L or R Arm | _____ Frequent Colds | _____ Eczema |
| _____ Numbness L or R Leg | _____ Headaches/Migraines | _____ Diabetes |
| _____ Low Back problems | _____ Ear Infections | _____ Menstrual Cramps |
| _____ Leg Problems L or R | _____ Dizziness | _____ Poor Digestion |
| _____ Pain b/t shoulders | _____ Fainting | _____ Diarrhea |
| _____ Pain in Joints | _____ Forgetfulness | _____ Constipation |
| _____ Loss of Feeling | _____ Depression | _____ Chest Pain |
| _____ Restricts Daily Activities | _____ Blurred Vision | _____ Pain at Night |
| _____ Restricts Exercise | _____ Difficulty Breathing | _____ Blood Pressure |
| _____ Unwanted Weight Gain | _____ Difficulty Walking | _____ Bowel / Bladder |
| _____ Unexplained Weight Loss | _____ Ringing in Ears Circle: High/Low | |
| _____ Unusual Fatigue | _____ Difficulty Speaking difficulties | |
| _____ Nausea / Vomiting | _____ Numbness on one side of face or body | |
| _____ Difficulty Swallowing | _____ Neck or Head Pain like never before | |
| _____ Other _____ | | |

Family Health History: Please list any condition (including those listed above) that your father, mother, spouse, brothers, sisters, or children have, or have had in the past. _____

Please rate how your pain / symptoms / health problems affect your Activities of Daily Living. Rate on a scale of 1-10, with 0 = No Problem to do / participate in the Activity, and 10 = extreme pain or problems doing the activity. If an Activity of Daily Living category does not apply to you, please leave it blank.

- | | | | |
|--------------------|-----------------------------------|---------------------------------|-----------------|
| _____ Bending | _____ Carrying | _____ Concentrating | _____ Dancing |
| _____ Doing Chores | _____ Doing Computer Work | _____ Dressing Driving | _____ Gardening |
| _____ Lifting | _____ Performing Sexual Activity | _____ Playing Sports | _____ Pushing |
| _____ Reading | _____ Recreating | _____ Rolling Over | _____ Running |
| _____ Shoveling | _____ Sitting to Standing | _____ Sitting | _____ Sleeping |
| _____ Standing | _____ Walking | _____ Watching TV | _____ Working |
| _____ Climbing | _____ Playing with kids/grandkids | _____ Other (please list) _____ | |

Sign _____ **Date** _____
 (Parent to sign if under 18)

Last time you had Spine X-rays _____
 FEMALES: Are you pregnant? ___ Yes ___ No ___ Not sure
 From past to present, please list by date and describe
 1. Car Accidents _____

 2. Falls / Injuries (Including Sports) / Work trauma (with date of trauma)

Medications and Supplements you now take _____

 Any known allergies to Medications / Supplements? ___ Y ___ N
 (If yes, please explain) _____

 List all surgeries you've had (with date of surgery) _____

AUTO ACCIDENT INFORMATION

Date and time of accident: on _____ at _____ a.m. p.m.
 Were you the: Driver Front Passenger Rear Passenger
 Make and model of the vehicle you were occupying? _____
 If a traffic violation was issued, to whom was it issued? _____
 Number of people in accident vehicle(the vehicle you were in) _____
 Did the police come to the accident site? Yes No
 Was a police report filed? Yes No
 Were there any witnesses? Yes No
 Were you wearing a seat belt? Yes No
 Was this vehicle equipped with airbags? Yes No
 If yes, did it/ they inflate? Yes No
 In relation to the base of your skull, where was the headrest? Above Below At base of skull
 What did your vehicle impact? Another vehicle Other _____
 Did any part of your body strike anything in the vehicle? Yes No
 If yes, please describe: _____
 Make and model of the other vehicle(s) involved? _____ N/A
 Name of the location/ street on which you were traveling? _____
 In which direction were you headed? N S E W
 What was the approx. speed of your vehicle? _____
 Did the impact to your vehicle come from the: Front Rear Right Side Left Side Other _____
 During impact, were you facing: Right Left Forward
 Were you aware or surprised by the impact?
 If accident vehicle made impact with another vehicle...
 Direction other vehicle was headed? N S E W
 Approximate Speed of the other vehicle? _____
 In your words, please describe the accident:

After Injury

Did accident render you unconscious? Yes No If yes, for how long? _____
 Please describe how you felt immediately after the accident: _____
 Have you gone to a hospital or seen any other Doctor? Yes No
 If yes, when did you go? just after accident the next day 2 days plus
 How did you get there? Ambulance Private transportation
 Name of hospital and/ or attending doctor: _____
 Was he/she a: D.C. M.D. D.O. D.D.S.
 Describe any treatment you received: _____
 Were X-Rays taken? Yes No
 Was medication prescribed? Yes No
 Have you been able to work since this injury? Yes No
 Are your work activities restricted as a result of this injury? Yes No
 Check the symptoms that are a result of this accident, and rate each symptom on a scale of 1 to 10 (1 = minimal, 10 = severe)

| | | |
|--|--|--|
| <input type="checkbox"/> Dizziness _____ | <input type="checkbox"/> Neck stiff _____ | <input type="checkbox"/> Numb feet/ toes _____ |
| <input type="checkbox"/> Memory loss _____ | <input type="checkbox"/> Jaw problems _____ | <input type="checkbox"/> Fatigue _____ |
| <input type="checkbox"/> Headache(s) _____ | <input type="checkbox"/> Arms/ shoulder pain _____ | <input type="checkbox"/> Shortness of breath _____ |
| <input type="checkbox"/> Blurred vision _____ | <input type="checkbox"/> Numb hands/fingers _____ | <input type="checkbox"/> Chest pain _____ |
| <input type="checkbox"/> Buzzing in ear _____ | <input type="checkbox"/> Stomach upset _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ears ringing _____ | <input type="checkbox"/> Nausea _____ | _____ |
| <input type="checkbox"/> Difficulty Sleeping _____ | <input type="checkbox"/> Back pain _____ | _____ |
| <input type="checkbox"/> Irritability _____ | <input type="checkbox"/> Lower back pain _____ | _____ |
| <input type="checkbox"/> Tension _____ | <input type="checkbox"/> Back stiffness _____ | _____ |
| <input type="checkbox"/> Neck pain _____ | <input type="checkbox"/> Leg pain _____ | _____ |

Is your condition(s) getting worse? Yes No Constant Comes and goes

Indicate your degree of comfort while performing the following activities, & if painful, rate the degree from 1-10, 10 being the worst.

| Comfortable | Uncomfortable | Painful | |
|-----------------------|--------------------------|--------------------------|--------------------------------|
| Lying on back..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Lying on side..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Lying on stomach..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Sitting..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Standing..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Stretching..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Lovemaking..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Walking..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Running..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Sports..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Working..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Lifting..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Bending..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Kneeling..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Pulling..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Reaching..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |

Have you retained an attorney: Yes No

If yes, whom? _____

His/ Her phone #: _____

Recovery

How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

- Standing Bending
- Sitting Operating equipment
- Walking Work with arms above head
- Lifting Typing
- Driving Stooping
- Twisting Other _____
- Crawling _____

What positions can you work in with minimum physical effort and for how long? _____ N/A

Prior to the injury were you capable of working on an equal basis with others your age? Yes No N/A

Do you work with others who can help you with any heavy lifting? Yes No N/A

While in recovery, is there any light duty work you could request? Yes No N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- I understand that I am directly and fully responsible for all professional bills submitted by Lifestyle Chiropractic for services rendered me. I hereby further give a Lien on my case to Lifestyle Chiropractic and associated healthcare providers against any and all proceeds of any settlement, judgment or verdict which may be paid to an attorney or myself as a result of the injuries for which I have been treated or injuries in connection therewith.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Sign _____ Date _____

(Parent to sign if under 18)

PERSONAL INJURY INSURANCE COVERAGE

Date of Accident _____

Patient Name _____

Insured Name _____

Insurance Company _____

Address _____ City _____ State _____ Zip _____

Phone Number _____

Claim Number _____ Policy Number _____

Has the accident been reported? Yes No

Name of adjuster handling claim _____

Will company accept assignment of benefits? Yes No
If not, will they make checks payable to patient and our office? Yes No
Are there any limits: Yes No How much? \$ _____ How much remains available? _____

GROUP HEALTH INSURANCE

Are there any medical benefits under auto insurance? Yes No
Insurance Company _____
Address _____ City _____ State _____ Zip _____
Phone Number _____
Insured Name _____
Agent _____ Policy# _____ Phone _____
Name and address of other party or parties involved in collision:

As a holistic, wellness-oriented office, it is our desire to help you improve every aspect of your life as it relates to your health.

How would you rate your diet? ___Poor ___Fair ___Good ___Excellent
How would you rate your exercise? ___Poor ___Fair ___Good ___Excellent
Please rate your stress levels on a scale of 1 to 10 with 1 = low and 10 = high ___Personal Stress ___Job Stress ___Other stress
Is there anything else you want the doctor to know? ___Y ___ N If yes, please state it here: _____

Sign _____ **Date** _____
(Parent to sign if under 18)

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on (child's name): _____,
by the licensed doctors of chiropractic, medical doctors, licensed physical therapists, and / or the doctor's trained representatives who may
be employed by or engaged in practice in this clinic.

If I have questions regarding informed consent, I will discuss with the doctor(s) the nature and purpose of the different physical
therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is
an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this
judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in
judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best
course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes
very rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk
associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had or will take the opportunity to ask questions about my
examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for
any future conditions for which I seek treatment.

**Female Patients: By initialing this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy
suspected or confirmed at this particular time. Initials: _____ Date of last menstrual period _____.**

HIPPA and Notice of Privacy Practices

I have been given a copy of and / or have access to the clinic's Notice of Privacy Practices which discusses how my PHI (Personal Health
Information) will be used for diagnosis, treatment, and payment on my account.

Patient's Name (Print) **Patient's Signature** **Date**

Relationship /authority if not signed by Patient **Witness**