Living Well Holistic Health, LLC

PERSONAL HISTORY

Date: _____ Social Security No: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Birth date: _____ Age: _____ Sex: M F

Business/Employer: _____ Type of Work: _____

Check One: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Separated No. of Children: _____

Name of Emergency Contact: _____ Phone No: _____

Referred to this office by: _____

Who is responsible for your bill: [ ] Self [ ] Spouse [ ] Workman's Comp. [ ] Medicaid [ ] Medicare

[ ] Auto Insurance [ ] Personal Health Insurance [ ] Other: _____

CURRENT HEALTH CONDITION

Purpose of this appointment: _____

_____

Other doctors seen for this condition: _____

When did this condition begin? _____

If disabled from work, please give dates: _____

[ ] Job related [ ] Auto related

Drugs you know take: [ ] Nerve Pills [ ] Pain Killers/Muscle Relaxers [ ] Blood Pressure Medicine

[ ] Insulin [ ] Other: _____

PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations: [ ] Appendectomy [ ] Tonsillectomy [ ] Gall Bladder [ ] Hernia

[ ] Broken Bones [ ] Other: _____

Major Accidents or Falls: _____

Hospitalization (other than above): _____

Previous Chiropractic Care: [ ] None

[ ] Doctor's name & approx. date of last visit: _____

Have you been treated for any health condition in the last year? [ ] Yes [ ] No

If yes, please explain: _____

BELOW IS A LIST OF CONDITIONS WHICH MAY SEEM UNRELATED TO THE PURPOSE OF YOUR APPOINTMENT. HOWEVER, THESE QUESTIONS MUST BE ANSWERED CAREFULLY AS THESE PROBLEMS CAN EFFECT YOUR OVERALL DIAGNOSIS, TREATMENT PLAN AND POSSIBILITY OF BEING ACCEPTED FOR CARE.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

[ ] Appendicitis
[ ] Scarlet Fever
[ ] Diphtheria
[ ] Typhoid Fever
[ ] Pneumonia
[ ] Rheumatic Fever
[ ] Polio
[ ] Malaria
[ ] Tuberculosis
[ ] Whooping Cough
[ ] Anemia
[ ] Measles
[ ] Mumps
[ ] Small Pox
[ ] Chicken Pox
[ ] Diabetes
[ ] Cancer
[ ] Heart Disease
[ ] Goiter
[ ] Influenza
[ ] Pleurisy
[ ] Alcoholism
[ ] Venereal Infection
[ ] Arthritis
[ ] Epilepsy
[ ] Mental Disorder
[ ] Lumbago
[ ] Eczema

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

[ ] Low Back Pain
[ ] Pain Between Shoulders
[ ] Neck Pain
[ ] Arm Pain
[ ] Joint Pain/Stiffness
[ ] Walking Problems
[ ] Difficult Chewing/Clicking jaw

NERVOUS SYSTEM CODE

[ ] Numbness
[ ] Paralysis
[ ] Dizziness
[ ] Forgetfulness
[ ] Confusion/Depression
[ ] Fainting
[ ] Convulsions
[ ] Cold/Tingling Extremities

GENERAL CODE

[ ] Allergies
[ ] Loss of sleep
[ ] Fever
[ ] Headaches

GASTRO-INTESTINAL CODE

[ ] Poor/Excessive Appetite
[ ] Excessive Thirst
[ ] Frequent Nausea
[ ] Vomiting
[ ] Diarrhea
[ ] Constipation
[ ] Hemorrhoids
[ ] Liver Trouble
[ ] Gall Bladder Problems
[ ] Weight Trouble
[ ] Abdominal Cramps
[ ] Gas/Bloating After Meals
[ ] Heartburn
[ ] Black/Bloody Stool
[ ] Colitis

GENITO-URINARY CODE

[ ] Bladder Trouble
[ ] Painful/Excessive Urination
[ ] Discolored Urine

C-V-R CODE

[ ] Chest Pain
[ ] Short Breath
[ ] Blood Pressure Problems
[ ] Irregular Heartbeat
[ ] Heart Problems
[ ] Lung Problems/Congestion
[ ] Varicose Veins
[ ] Ankle Swelling

EENT CODE

[ ] Vision Problems
[ ] Dental Problems
[ ] Sore Throat
[ ] Ear Aches
[ ] Hearing Difficulty
[ ] Stuffed Nose

MALE/FEMALE CODE

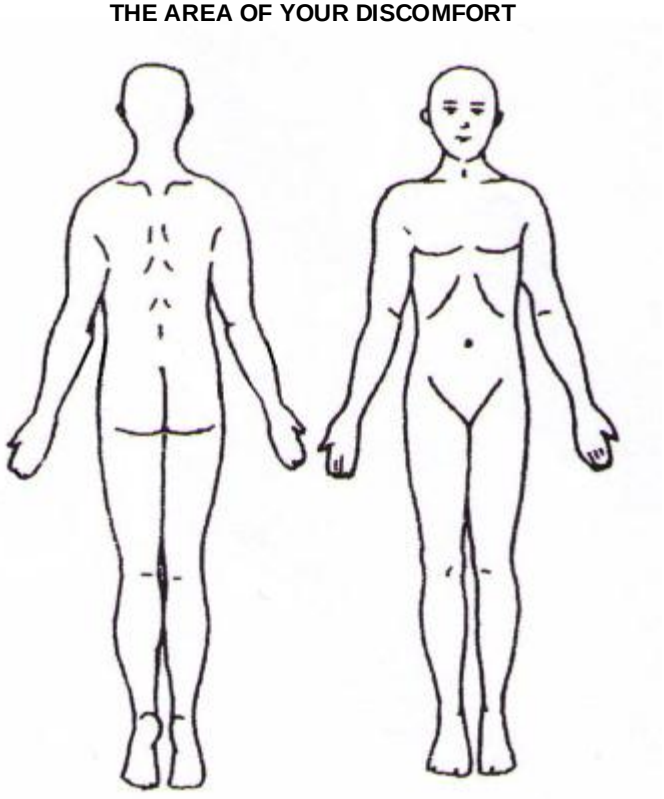
[ ] Menstrual Irregularity
[ ] Menstrual Cramping
[ ] Vaginal Pain/Infections
[ ] Breast Pain/Lumps
[ ] Prostate/Sexual Dysfunction
[ ] Genital Herpes

FEMALES ONLY:

When was your last period? _____

Are you pregnant? [ ] Yes [ ] No [ ] Maybe

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF YOUR DISCOMFORT



1 2 3 4 5 6 7 8 9 10

PLEASE INDICATE THE SEVERITY OF PAIN (10 BEING THE WORST)

DO NOT WRITE BELOW THIS LINE

Diagnosis:

Patient Accepted: [ ] Yes [ ] No

_____

Doctor's Signature

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your doctor will weigh your needs and desires when recommending your treatment program.

If this is an accident related injury, please fill out the Accident Form. Thank You!

THE PURPOSE OF OUR CHIROPRACTIC CENTER IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC AND IN TURN EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ SS# _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____