New Patient Information

Name ______________________ Date __________ Date of Birth ____________

Address ______________________ City __________ State ______ Zip _________

Cell Phone #____________________ Secondary Phone #______________________

Email address ______________________ Employer ______________________

Marital Status: **M S W D** Spouse's Name __________________ Number of Children________

How did you hear about our office? ____

<u>Reason For Visit</u>: ☐ Health Problem ☐ Work Injury ☐ Auto Accident

<u>I. HEALTH CONCERNS</u>

List health concerns according to their severity	Rate the Severity 1 (mild) – 10 (worst imaginable)	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	% of time pain is present
1.________________	________	________	________	________	________
2.________________	________	________	________	________	________
3.________________	________	________	________	________	________
4.________________	________	________	________	________	________

Since the problem started is it: _____ About the same _____ Getting better _____ Getting worse

What have you done for this condition(s)? Was it of benefit?

____

____

How is your symptom/condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other________	☐	☐	☐	☐

What is it that you <u>can't</u> do or do freely now? ______________________________

What would you <u>like</u> to do again or better? Something you enjoy ____________________

How would your life be better if you had perfect health?______________________

II. GENERAL HEALTH HISTORY SECTION

Mark any of the following conditions you have had in the **past** with **(√)** or any **current** conditions with a **(+)**

General
__Dizziness
__Swelling
__Trouble concentrating
__Cold sweats
__Irregular sleep
__Spaciness
__Fatigue

Head/Neck
__Headaches
__Head feels too heavy
__Neck pain
__Teeth grinding/TMJ
__Grating in neck
__Tight shoulder muscles
__Pinched nerve

Back/Arms/Legs
__Mid-back pain
__Disc herniation
__Low back pain
__Leg/feet pain
__Arms/hand pain
__Pins/needles hands/feet
__Cold hands/feet

Cardiovascular/Respiratory
__Chest pains
__Heart palpation
__Heart attacks
__High/low blood pressure
__High Cholesterol
__Asthma
__Shortness of breath

Women Only
__Menstrual cramps
__Menstrual irregularity
__Hot Flashes/Menopause
__Endometriosis/Cysts

Mental/Emotional
__Irritability
__Depression
__Anxiety
__Nerves & nervousness

Ears/Nose/Throat
__Thyroid trouble
__Ringing in ears
__Sinuses
__Re-current infections
__Allergies

Digestive
__Indigestion/gas
__Ulcers
__Irritable bowel
__Constipation/diarrhea
__Gallbladder trouble
__Liver trouble

Other
__Arthritis
__Cancer
__A.D.D./A.D.H. D
__Diabetes
__Anemia
__Fibromyalgia

__Other (please explain) ____
____

Have you had any surgery? (Please include all surgery)

1. Type ______________________________________ When ____________
2. Type ______________________________________ When ____________
3. Type ______________________________________ When ____________
4. Type ______________________________________ When ____________

Accidents and/or injuries: auto, work-related, or other (Especially those related to your present problems)

1. Type______________________________ When__________ Hospitalized _____Yes _____No
2. Type______________________________ When__________ Hospitalized _____Yes _____No
3. Type______________________________ When__________ Hospitalized _____Yes _____No

CURRENT MEDICINE(S)/SUPPLIMENTS:

Please list any medications you have taken in the past 2 months and why: (prescription and over-the-counter)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Name of other Doctor's seen for this condition(s):
"Limited Scope" Chiropractor (Focuses on short term neck and back pain relief)

____

"Wellness" Chiropractor (focuses on overall health as well as underlying cause of pain and health concerns)

____

Medical Dr. __________________ /____________________ Specialist ___________________ / __________________

Other ____

III. STRESS HEALTH HISTORY:

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

What is your average daily stress?

None 1 2 3 4 5 6 7 8 9 10 Extreme

Where in your body do you hold stress?

____

Do you think your health problem is caused by:

☐ physical stress ☐ chemical stress ☐ emotional stress ☐ combination of all three

Please list your top two stresses you have (current) or had (past) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. ____
   b. ____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. ____
   b. ____
3. Psychological/Emotional stress (work, relationships, finances, self-esteem, etc.)
   a. ____
   b. ____

Why do you think your body failed to heal itself this time? ___________________________________

____

____

Is there anything else which may help to better understand you which has not been discussed?

____

____

Dr. Kris Arnold
Dr. Jason Stephens, Dr. Randy Tabita
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814-624-0606

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept a practice member for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each practice member understands both the objective and the method that will be used to obtain it. This will prevent any confusion.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of subluxation. Our Chiropractic method of correction is by specific, gentle adjustments.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Subluxation: An impediment in the brain and nervous system which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to regulate and heal itself. Subluxations appear as the colored bars on the computer scans.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a chiropractic 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.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct subluxations.

I, ___________________________________ have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

_____________________________________ ______________________
Signature Date

I hereby authorize the release, use, or disclosure of my health information by Live Well Chiropractic for purposes of treatment, payment, or healthcare operations. I understand that I may revoke this authorization at any time in writing. This authorization will remain in effect unless otherwise stated by myself or LWC.
I understand that I may request a copy of the privacy policy of LWC.

_____________________________________ ______________________
Signature Date

You may discuss my health information with the following people:

_____________________________________ _____________________________________
_____________________________________ _____________________________________