

# 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? \_\_\_\_\_

**Have you used any other Live Well Services:**  Massage  PEMF  S-Wave  Nutritional Coaching

**Reason For Visit:**  Health Problem  Work Injury  Auto Accident

## I. HEALTH CONCERNS

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?

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What is it that you can't do or do freely now? \_\_\_\_\_

What would you like 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

### 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

### Mental/Emotional

- Irritability
- Depression
- Anxiety
- Nerves & nervousness

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?

\_\_\_\_\_

\_\_\_\_\_



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## 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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_