Welcome – We're Glad You Are Here

LAST NAME: ______________________________________FIRST: _____________________________MI: _____

ADDRESS: ___________________________________CITY: ____________________STATE: _____ZIP_________

(HM): __________________ (CELL) __________________ E-MAIL: _____________________________________

BIRTH DATE: _____/____/_____ SEX: ☐ M ☐ F Age: ___________ OCCUPATION: _________________________

EMPLOYER: _________________________ADDRESS: ______________________PHONE: ___________________

EMERGENCY CONTACT/RELATIONSHIP: _____________________________PHONE: ______________________

HOW DID YOU HEAR ABOUT US? ☐ DOCTOR ☐ INTERNET ☐ PATIENT ☐ INSURANCE COMPANY ☐ OTHER

WHO CAN WE THANK FOR REFERRING YOU? ____

Insurance Information

Type: ☐Health Insurance ☐Auto Accident ☐Work Comp ☐Personal Injury ☐Self/Cash

PRIMARY INSURANCE CARRIER: ____

SECONDARY INSURANCE CARRIER: ____

Financial Policy

ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICE IS RENDERED:

I understand that health and accident insurance policies are an arrangement between my insurance carrier and myself. I also understand that the Doctor's office will prepare and submit any claims and requested reports as a courtesy to me. However, I clearly understand that I am ultimately responsible for all services charged to me and that I am directly responsible for the payment. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable. I understand that I am responsible for all collection agency fees; pre-judgment interest at 1 ½ percent per month; and any and all fees/ expenses incurred arising out of collections efforts. I hereby authorize for the doctors to use all physical medicine, therapy modalities, exam, & diagnostic tests/x-rays, he or she deems appropriate in my case.

Patient's Signature ____**Date:** ______________________

Guardian's Signature if patient is a minor _______________________________________**Date:** _________________

Medical History

If you have had any surgical operations, or overnight stays in the hospital, state the year and the illness/operation. Start with the most recent event.

Year	Illness/Operations	Year	Illness/Operations

Medication / Supplements	Dose	Times / Day

Any known allergies? ____

Any family history of disease or illness: ☐ **heart disease** ☐ **cancer** ☐ **diabetes** ☐ **stroke**
Other:____

Have you had imaging (Xray or MRI) recently? ☐Yes ☐No Region_____________ Clinic_________________

Who is your primary care physician? ____

Social History

Describe your work activity (sit, stand, lift, computer, etc) ____

Do you now or have you ever consumed? ☐ Cigarettes ☐ Alcohol ☐ Coffee/Tea ☐ Street Drugs

How would you rate your current health? ☐ Poor ☐ Fair ☐ Good ☐ Great

Do you currently exercise? ☐Yes ☐No Describe_____________________

Are you pregnant (female only for xray purposes)? ☐Yes ☐No Number of weeks______

What are your goals at LMC/IMS? Improved… ☐ Pain ☐ Energy ☐ Sleeping ☐ Concentration ☐ Exercise ☐ Stress ☐ Weight Loss ☐ Nutrition ☐ Other ___________________________

Have you been experiencing any of the following?

Y N
☐ ☐ Numbness in your hands or feet
☐ ☐ Numbness in the groin or rectal area
☐ ☐ Pain that is worse in the middle of the night
☐ ☐ Sustained major trauma like an accident or fall
☐ ☐ Previous history of cancer
☐ ☐ Bowel or bladder (bathroom) problems
☐ ☐ Recent unexplained weight loss or weight gain

Y N
☐ ☐ Blurred vision
☐ ☐ Double vision
☐ ☐ Trouble swallowing or speaking
☐ ☐ Dizziness
☐ ☐ Fainting Spells
☐ ☐ Nausea
☐ ☐ Trouble with walking or balance

Review of Systems

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES / CONDITIONS YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Influenza
- ☐ Cancer _______________
- ☐ Heart Disease
- ☐ Stroke
- ☐ Heart Attack
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Pleurisy
- ☐ Arthritis (Osteo / Rheumatoid)
- ☐ Epilepsy
- ☐ Eczema
- ☐ Hepatitis
- ☐ Frequent Headaches
- ☐ Asthma
- ☐ Concussion
- ☐ Mental Disorders
- ☐ Other: _______________

Have you tested HIV positive? ☐ Yes ☐ No

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

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Hip Pain (Right / Left)
- ☐ Knee Pain (Right / Left)
- ☐ Foot/Ankle Pain (Right / Left)
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Shoulder Pain (Right / Left)
- ☐ Arm Pain (Right / Left)
- ☐ Hand/Wrist Pain (Right / Left)
- ☐ General Joint Pain / Stiffness / Arthritis
- ☐ Walking Problems
- ☐ Difficult Chewing / Clicking Jaw
- ☐ Localized Weakness
- ☐ Muscle Pain / Weakness

NERVOUS SYSTEM

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness / Poor Balance
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Numb/Tingling Hands or Feet
- ☐ Stress / Anxiety
- ☐ Seizures
- ☐ ADD / ADHD

GENITO / URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Blood In Urine
- ☐ Kidney Stones
- ☐ Sexually Transmitted Disease(s)
- ☐ Genital Herpes
- ☐ Discolored Urine
- ☐ Unable To Hold Urine

CARDIOVASCULAR / RESPIRATORY

- ☐ Chest Pain
- ☐ Shortness Of Breath
- ☐ Blood Pressure Problems: Low / High
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems: Congestion / Emphysema
- ☐ Varicose Veins
- ☐ Swelling In Ankles / Hands / Feet
- ☐ Cold Hands Or Feet
- ☐ Blood Clots
- ☐ Phlebitis
- ☐ Fainting
- ☐ High Cholesterol

EYES / EARS / NOSE / THROAT

- ☐ Vision Problems
- ☐ Dental Problems / Teeth Grinding
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Ringing In Ears
- ☐ Sinus Problems
- ☐ Facial Pain
- ☐ Migraines

MALE / FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Painful Periods
- ☐ Vaginal Pain / Infection
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction
- ☐ Vasectomy / Tubal Legation

FEMALES ONLY:

When Was Your Last Period?

____

Are You Pregnant? Yes No Not Sure
(In Case X-Rays Are Required)

GASTRO-INTESTINAL

- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Unexplained Weight Loss / Gain
- ☐ Abdominal Cramps / Pain
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis
- ☐ Belching
- ☐ Indigestion
- ☐ Bad Breath

SKIN AND HAIR

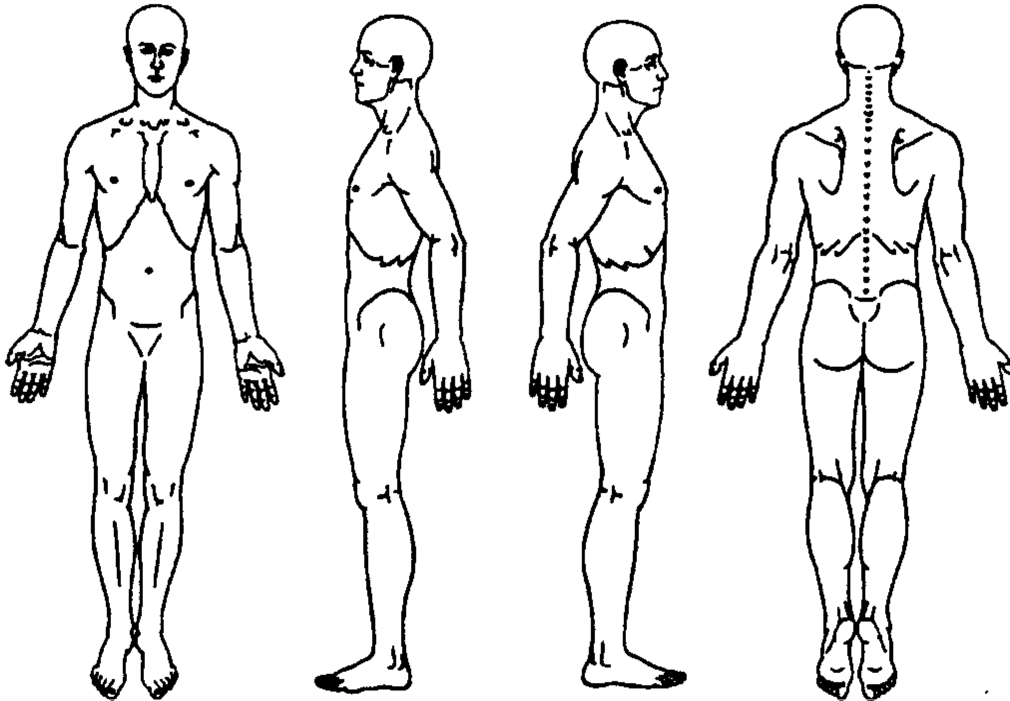
- ☐ Bleed or Bruise Easily
- ☐ Rashes
- ☐ Itching
- ☐ Change In Hair Or Skin Texture
- ☐ Dandruff
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of Hair
- ☐ Pimples
- ☐ Recent Moles

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Poor Sleeping
- ☐ Fever
- ☐ Headaches
- ☐ Poor Balance
- ☐ Other: ___________________

Name: ______________________________ Date: ______________________

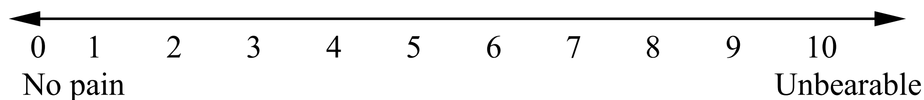
Mark Your Pain



Describe Your Pain

Area of complaint:____
When did your symptoms begin? ______________________________
How did your symptoms begin? _______________________________
Have you had these symptoms in the past? _____________________

Rate your pain:



Check all that apply to your area of complaint

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Shooting
- ☐ Ache
- ☐ Soreness
- ☐ Weakness
- ☐ Throbbing
- ☐ Tingling
- ☐ Numbness
- ☐ Dull
- ☐ Radiates to___________

Pain is made worse by:____

Pain is made better by:_______________________________________

How often are your complaints present?

- ☐ Constant 100% of the time
- ☐ Frequently 75%
- ☐ Intermittent 50%
- ☐ Occasional 25%

Is your Pain ☐ Increasing ☐ Decreasing ☐ Not Changing

Have you seen anyone else for this complaint? ☐ Yes ☐ No

Explain:____

Patient Acknowledgement of Receipt of Notice of Privacy Policies

Patient Name ________________________________ Date ____________

I acknowledge that I have reviewed the Informed Consent, Disclosure of Health Information, and Consent to Communicate forms.

Initials _________ Yellow Page: Consent For use and Disclosure of Health Information.

Request Copy?

- Yes
- No

Initials _________ Pink Page: Informed Consent To Chiropractic Treatment

Request Copy?

- Yes
- No

Initials _________ Blue Page: Consent To Communicate Protected Health Information by Email/SMS

Request Copy?

- Yes
- No

______________________________________ _________________
Signature of Patient Date

______________________________________ _________________
Witness (Office Staff) Date