Welcome to our office!

Please feel free to ask any questions at any time to our Team Members here in the office. We look forward to a healthy relationship with you and your family.

Name: ____ Date of Birth: _____________ Sex: ☐ Male ☐ Female
Street: ____ Apt: _____________
City: ____ State: ________________ Zip: ____________________
Home Telephone: ______________________________ Mobile Telephone: ______________________________
Occupation: __________________________________ Student ☐ Veteran/Military ☐
Email Address: ____ SSN#: ____________________________
Emergency Contact: ______________________ Relationship: ____________ Telephone: _________________

Responsible Party (Parent or Guardian)

Name of Person responsible for this account: ___________________________ Relationship to Patient: _______
Address ____
Email: ____ Cell Phone: ___________ DOB: _________________

Family Survey

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered Partner's Name: ___________________
Do you have children? ☐ Yes ☐ No If yes, how many? ___ Have they been checked by a Chiropractor? ___
What are their names and ages? ____

Family Medical History

	Age	Disease	If Deceased, Cause of Death
Father	_____	______________________________	______________________________
Mother	_____	______________________________	______________________________
Siblings	_____	______________________________	______________________________
	_____	______________________________	______________________________
	_____	______________________________	______________________________
Spouse	_____	______________________________	______________________________
Children	_____	______________________________	______________________________
	_____	______________________________	______________________________
	_____	______________________________	______________________________

Lifestyle Habits

How many times per week do you exercise? □Never □1-2 □3-4 □5-6
What do your daily work habits include? (i.e. sitting, standing, light labor, heavy labor, computer work)
____
How would you rate your eating habits? ☐ Poor ☐ Fair ☐ Good ☐ Excellent
What vitamins and nutritional supplements do you currently take? ______________________________
Do you smoke? □ No □ Yes How much per day? ________________
How often do you consume alcohol on a weekly basis? _______________
How much coffee or caffeinated beverages do you consume on a daily basis? _____________
How many hours of sleep do you get per day? ______
Are there any other health habits that you could share with us? ______________________________
____
____

FOR OFFICE USE ONLY	○ Check all signatures ○ Insurance Verification ○ Enter into MailChimp and ChiroTouch ○ Provider Initials______ ○ Copy Drivers' License if needed (BCBS, Anthem)

Name: ______________________ DOB: __________ Date: __________

PRIOR HEALTH AND WELLNESS CARE TREATMENT INFORMATION

Name of Chiropractor: ______________________ Location (city): ______________________
When was your last adjustment? __________ Have you had x-rays/scans? ______________________
Name and Contact of Massage Therapist: ______________________ Last Massage: __________
Gym or Health Club: ______________________ Last Training Session: __________

MEDICAL DOCTOR: Living Well Balanced, PC believes in a multidisciplinary approach. If you would like us to send your care plan and objective findings to your family physician or any other health care providers, we will send all your evaluations and progress reports to the address listed below. ☐ Yes ☐ No

NAME: ______________________ SPECIALTY: ______________________
ADDRESS: ______________________

HEALTH HISTORY Chief Complaint: ______________________

Location: ______________________
(Where is the pain/problem?)

Quality: ______________________
(Type of pain)

Severity: ______________________
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: ______________________
(How long have you had this pain/problem? When did it start?)

Timing: ______________________
(Does the pain/problem occur at a specific time?)

Context: ______________________
(Where were you at the onset of this pain/problem?

Associated Signs/Symptoms ______________________
(What other associated problems have you been having?)

Modifying Factors: ______________________
(What makes the pain/problem worse or better? Have you had previous episodes?)

What treatment have you already received for your condition?
☐Medication ☐Surgery ☐Physical Therapy ☐Other______________________

PAST MEDICAL HISTORY

Check only those conditions which are applicable:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other

List any types of surgeries which you have had and the dates which they occurred: ______________________
____
Please list all medications you are currently taking (included OTC): ______________________
____
Allergies: ______________________
(For Women) Are you pregnant? ☐Yes ☐ No; Nursing? ☐Yes ☐ No; Taking birth control pills? ☐Yes ☐ No

Name: ______________________________ DOB: __________ Date: __________

MEDICAL SYMPTOMS QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile for the past 30-60 days.

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD
0 1 2 3 4 Headaches
0 1 2 3 4 Faintness
0 1 2 3 4 Dizziness
0 1 2 3 4 Insomnia

Total _______

EYES
0 1 2 3 4 Watery or Itchy Eyes
0 1 2 3 4 Swollen, Reddened or Sticky Eyelids
0 1 2 3 4 Bags or Dark Circles under Eyes
0 1 2 3 4 Blurred or Tunnel Vision
(does not include near or far-sighted)

Total _______

EARS
0 1 2 3 4 Itchy Ears
0 1 2 3 4 Earaches, Ear Infections
0 1 2 3 4 Drainage from Ear
0 1 2 3 4 Ringing in Ears, Hearing Loss

Total _______

NOSE
0 1 2 3 4 Stuffy Nose
0 1 2 3 4 Sinus Problems
0 1 2 3 4 Hay Fever
0 1 2 3 4 Sneezing Attacks
0 1 2 3 4 Excessive Mucus Formation

Total _______

MOUTH/THROAT
0 1 2 3 4 Chronic Coughing
0 1 2 3 4 Gagging, Frequent Need to Clear Throat
0 1 2 3 4 Sore Throat, Hoarseness, Loss of Voice
0 1 2 3 4 Swollen/Discolored Tongue, Gums or Lips
0 1 2 3 4 Canker Sores

Total _______

SKIN
0 1 2 3 4 Acne
0 1 2 3 4 Hives, Rashes, Dry Skin
0 1 2 3 4 Hair Loss
0 1 2 3 4 Flushing, Hot Flashes
0 1 2 3 4 Excessive Sweating

Total _______

HEART
0 1 2 3 4 Irregular or Skipped Heartbeat
0 1 2 3 4 Rapid or Pounding Heartbeat
0 1 2 3 4 Chest Pain

Total _______

LUNGS
0 1 2 3 4 Chest Congestion
0 1 2 3 4 Asthma, Bronchitis
0 1 2 3 4 Shortness of Breath
0 1 2 3 4 Difficulty Breathing

Total ______

DIGESTION
0 1 2 3 4 Nausea, Vomiting
0 1 2 3 4 Diarrhea
0 1 2 3 4 Constipation
0 1 2 3 4 Bloated Feeling
0 1 2 3 4 Belching, Passing Gas
0 1 2 3 4 Heartburn
0 1 2 3 4 Intestinal/Stomach Pain

Total _______

JOINTS/ MUSCLES
0 1 2 3 4 Pain or Aches in Joints
0 1 2 3 4 Arthritis
0 1 2 3 4 Stiffness or Limitation of Movement
0 1 2 3 4 Pain or Aches in Muscles
0 1 2 3 4 Feeling of Weakness or Tiredness

Total _______

WEIGHT
0 1 2 3 4 Binge Eating/Drinking
0 1 2 3 4 Craving Certain Foods
0 1 2 3 4 Excessive Weight
0 1 2 3 4 Compulsive Eating
0 1 2 3 4 Water Retention
0 1 2 3 4 Underweight

Total _______

ENERGY/ ACTIVITY
0 1 2 3 4 Fatigue, Sluggishness
0 1 2 3 4 Apathy, Lethargy
0 1 2 3 4 Hyperactivity
0 1 2 3 4 Restlessness

Total _______

MIND
0 1 2 3 4 Poor Memory
0 1 2 3 4 Confusion, Poor Comprehension
0 1 2 3 4 Poor Concentration
0 1 2 3 4 Poor Physical Condition
0 1 2 3 4 Difficulty in Making Decisions
0 1 2 3 4 Stuttering or Stammering
0 1 2 3 4 Slurred Speech
0 1 2 3 4 Learning Disabilities

Total _______

EMOTIONS
0 1 2 3 4 Mood Swings
0 1 2 3 4 Anxiety, Fear, Nervousness
0 1 2 3 4 Anger, Irritability, Aggressiveness
0 1 2 3 4 Depression

Total _______

OTHER
0 1 2 3 4 Frequent Illness
0 1 2 3 4 Frequent or Urgent Urination
0 1 2 3 4 Genital Itch or Discharge

Total _______

GRAND TOTAL ____

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

YOU MAY BE ENTITLED TO A DISCOUNT UNDER THE FOLLOWING CIRCUMSTANCES (FOR CHIRO ONLY):

- If you are a member of a DMPO, such as ChiroHealthUSA. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is $49/year and covers you and your dependents. Ask our Team for more information on how to join.
- Patients who meet state and or federal poverty guidelines or other circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the Office. Verification will be required.

Do you have any Medical insurance? □ Yes □ No If yes, complete the following:

Name of Insured: ________________________________ Relationship to Insured: _______________

Insurance Carrier: ________________________ ID#: ____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay LWB Health Associates, PLLC DBA Living Well Balanced, Holistic and Integrative Healthcare as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ I instruct the Health Professionals here to deliver the care that, in their professional judgment, can best help me in the restoration of my health. I also understand that the care offered in this practice is based on the best available scientific evidence and designed to reduce or correct stress on the brain, body and nervous system.

Initials ____ I may request a copy of the Privacy Policy and understand it describes how my professional health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials ____ I grant permission to be called to confirm or reschedule an appointment & to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials ____ I authorize care for myself or my minor child by the Doctors and Team Members at this office.

Initials ____ I certify that the information I provide to my Doctor(s) and/or insurance company is correct. I certify that I am here to receive health care and for no other purpose. I do not represent any third party.

If the patient is a minor child, print child's full name: ______________________________

______________________________ ____________________

Your Signature **Date**