Life Care Chiropractic & Wellness Center

New Patient Information Form

If this appointment is for a condition related to an auto or work injury please STOP HERE and inform the receptionist. Thank you.

Last________________________First________________________MI___Date__________________

Address ________________________________ City _________________ State _____ Zip ________

Phone ________________ SS# _______________ Age _____ Birth date ___________ Sex ____ Cell Phone __________________ Email Address ____

Employer ________________________ Occupation ___________________ Work# ______________

Work Address _____________________________ City _______________ State ____ Zip _________

Marital Status ( ) S ( ) M ( ) D ( ) W Number of Children _______ Ages ___________________

Spouse-Last _________________ First ________________ MI___ DOB______ SS#______________

Spouse's Employer _____________________ Occupation _______________ Work#______________

FOR DEPENDENT PATIENT ONLY-PARENT OR LEGAL GUARDIAN

Father _____________________ Address ____________________________ Phone ______________

Employer __________________ Address ____________________________ Phone ______________

Mother ____________________ Address ____________________________ Phone ______________

Employer __________________ Address ____________________________ Phone ______________

Father's SS# ________________DOB _________ Mother's SS#______________DOB ___________

Have you ever received chiropractic care from another clinic or doctor? ________________________

If so, what clinic or doctor was seen? ____

When were you last seen by the previous provider? ____

In what ways have you heard about our practice? (check all that apply)

Yellow Pages ( ) Public information booth ( ) Advertisement ( ) Referral from a friend ( ) Angie's List ( )
Yelp/Google Review ( ) Internet Search ( ) Facebook ( ) Other ( ) ____________________________________
*If you were referred by a friend whom may we thank for the referral?*____________________________________

I agree to participate in medical and therapy treatments by this provider and accept that no guarantee of results or outcome is expressed. I clearly understand that all services rendered to 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 to me will be immediately due and payable.

Patient Signature ____ Date ________________

Guardian's Signature (For Minor Child) ______________________________ Date________________

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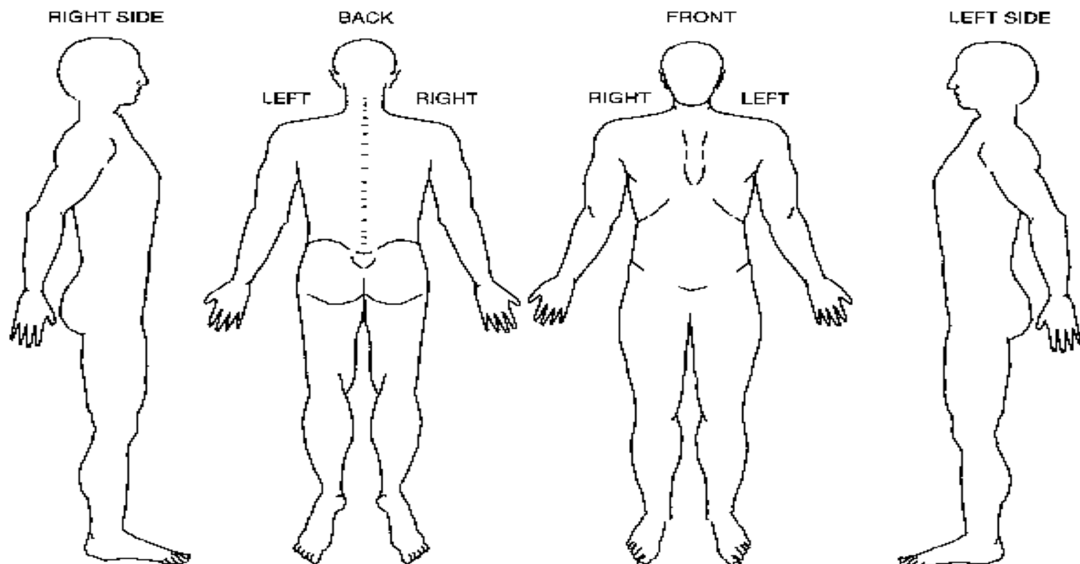
Medical History

Patients Name ____ **Date** _________________________
Major complaint/purpose of this appointment ____
Other complaints____
Is condition due to injury arising from ( ) Employment ( ) Auto Accident ( ) Sport ( ) Home
( ) Other_________________________
Date first symptom appeared _________ Have you had this or similar conditions in the past? _______
What activities aggravate this condition? ____
Is this condition interfering with ( )Work ( ) Sleep ( ) Daily Routines ( ) Other
Is this condition ( ) Getting worse ( ) Improving ( ) Constant ( ) Varies
Other doctors seen for this condition and date_________________________ Date Last X-rays_______
Have you been treated by a physician for ANY other health condition in the last year? _____________
If so, by whom____________________________ For what conditions__________________________
List all prescription medications you are currently taking and the purpose of each
____
List all nonprescription medications you are currently taking and the purpose of each
____
List any vitamins or supplements you are currently taking
____
List any previous surgeries____
List any previous bone fractures____

Pain Chart

Please mark area(s) of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Numbness	Pins and needles	Burning	Aching	Stabbing
-------------	OOOOOO	^^^^^^	xxxxx	• • •



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Symptom Survey

Patients Name____ **Date**__________________

INSTRUCTIONS: Number the symptoms that apply to you. Use (1) for mild symptoms (occur once or twice a year), (2) for moderate symptoms (occur several times a year), (3) for frequent symptoms (you are aware of it almost constantly). CIRCLE THE SYMPTOMS THAT CONCERN OR BOTHER YOU MOST:

Head
__Headaches
__ Sinus
__ Light-headedness
__ Loss of memory
__ Fainting
__ Blurred vision
__ Double vision
__ Loss of vision
__ Dizziness
__ Ringing in ears
__ Buzzing in ears
__ Pain in ears

Neck
__ Pain in neck
__ Pinched nerve in neck
__ Neck feels out of place
__ Muscle spasms in neck
__ Grinding or popping sounds

Shoulders
__ Pain in shoulder joint (R – L)
__ Pain across shoulders
__ Difficulty in starting
__ Bursitis (R – L)
__ Muscle spasms in shoulders
__ Tension in shoulders

Arms & Hands
__ Pain in arm
__ Pain in hands
__ Pain in fingers
__ Tingling
__ Numbness
__ Joint Pain

Abdomen
__ Nervous stomach
__ Gas
__ Diarrhea
__ Hemorrhoids
__ Nausea
__ Urinary frequency
__ Constipation

Chest
__ Chest pain
__ Shortness of breath
__ Rib pain
__ Irregular heartbeat
__ Breast pain
__ Heart conditions

Hips, Legs & feet
__ Pain in buttocks
__ Pain in hip
__ Pain down leg
__ Knee pain
__ Leg cramps
__ Numbness in legs
__ Numbness in feet

Women Only
__ Menstrual pain
__ Irregularity
__ Hysterectomy
__ Genital cancer
__ Discharge
__ Menopause
__ Tumors

Men Only
__ Night Urination
__ Prostate pain/ swelling

Back
__ Upper back pain
__ Mid back pain
__ Low back pain
__ Muscle pain

General: CHECK ANY OF THE FOLLOWING CONDITONS THAT YOU EXPERIENCE

__ Diabetes
__ Heart Attack/ Disease
__ Cancer
__ Stroke
__ Ulcers
__ Aids/HIV
__ High blood pressure
__ Low blood pressure
__ Tuberculosis
__Arthritis
__ Thyroid problems
__ Kidney problems
__ Asthma
__ Epilepsy/convulsions
__ Insomnia

Please list any other health conditions not mentioned above_______________________________________

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Assignment and Instruction for Direct Payment to Doctor
Private and Group Accident and Health Insurance

Patient: ____

Claim / Group: ____

SS#/ID#: ____

I hereby instruct and direct the ______________________________________ insurance company to pay by check made out and mailed directly to:

Life Care Chiropractic and Wellness Center, LLC
1 Post Office Road
Suite 102
Waldorf, MD 20602

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Life Care Chiropractic and Wellness Center, LLC

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as a payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at Life Care Chiropractic and Wellness Center, this ___ day of 20__.

____ __________________________________

Signature of Policy Holder Witness

____

Signature of Claimant, if other than policy holder

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FEMALE PATIENTS ONLY

ALL FEMALE PATIENTS of the Life Care Chiropractic & Wellness Center are asked to answer the following questions concerning possible pregnancy. This information is ONLY for providing the patient with radiation protection, and its release is governed by the PRIVACY ACT.

1. Have you had an operation which has made you sterile?

   Yes __ No __ If yes, what type? ____

2. Do you use birth control measures regularly?

   Yes __ No __ If yes, what form? ____

3. Is there **any** possibility that you could be pregnant now?

   Yes __ No __

4. Date of last menses ______________________

   Patient's Signature: ____________________________ Date _________________________

PRIVACY ACT STATEMENT: Authority Section 108, 1071-87, 3012, 5031, and 8012, Title 10, United States Code and Executive Order 9397.

PURPOSE: To document possibility of pregnancy in all women of childbearing age.

ROUTINE USES: To prevent x-ray exposure to potentially pregnant females.

DISCLOSURE IS MANDATORY: Failure to disclose the required information will result in possible delay or cancellation of x-ray examination.