LIVING WELL
SPINE CENTER

New Patient Information
ADULT

Today's date: _____

Who are you?

Patient's name: _____

Address: _____

City, state & zip: _____

Home phone: _____ Cell: _____

Social security number: _____

Birth date: _____ Age: _____

E-mail address: _____

Who do we contact in case of an emergency?

Contact: _____ Phone: _____

Where would you prefer to be contacted? _____

Are you employed?

If so, employer: _____ Phone: _____

Address: _____

Do you have a family doctor or dentist?

Family doctor: _____

Phone: _____

Family dentist: _____ Phone: _____

Whom may we thank for referring you: _____

Previous chiropractor: _____

I will be paying by: ☐ Cash ☐ Check ☐ MasterCard ☐ Visa ☐ Discover

Would you like to receive our e-mail newsletter? ☐ Yes ☐ No

Do you experience any of these health problems?

☐ Headaches	☐ Pulled muscles	☐ Car accident	☐ Sinus pain/allergies
☐ Sleeping problems	☐ Stressed shoulders	☐ Leg & hip pain	☐ Scoliosis
☐ Emotional stress	☐ Wrist or joint pain	☐ Neck pain	☐ Stiffness
☐ Numbness	☐ Work injury	☐ Lower back pain	☐ Stomach/digestive trouble
☐ Mid-back pain	☐ Loss of energy	☐ Lack of exercise	☐ Frequent colds/flus

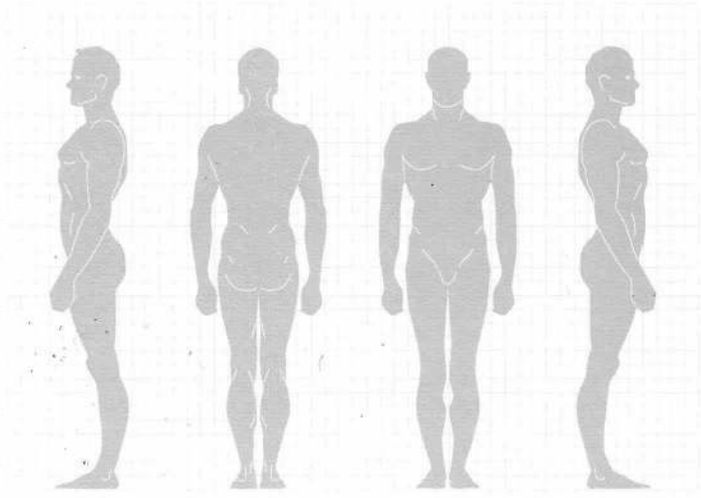
Current health problems: _____

Currently taking medications: _____

Do these conditions interrupt...

☐ Career ☐ Sleep pattern ☐ Ability to exercise ☐ Family life ☐ Social life

Where are your problem areas?



Left side Back Front Right side

What methods have you tested?

☐ Exercise ☐ Physical therapy ☐ Prescription drugs ☐ Massage ☐ Nothing

What's your condition:

How long have you been living this way? Weeks: Months: Years:

Would you like to find the cause of your problem(s)? ☐ Yes ☐ No ☐ Maybe

What results would you want for yourself?

☐ Reduce pain ☐ Restore health ☐ Maintain health

Signature of Agreement

I understand and agree that health insurance is an agreement between the carrier and myself. I understand and agree 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 care, any fees for professional services rendered to me will be immediately due and payable.

Signature: _____ Date: _____

Acknowledgement of HIPPA Privacy Act

My signature acknowledges I have read and understand the HIPPA Act.

Signature: _____ Date: _____

Personal representative name printed: _____

Personal representative signature: _____

Relationship to patient: _____ Date: _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare/Insurance, your health information on this form may be shared with Medicare/Insurance. Your health information which Medicare/Insurance sees will be confidential.