LIVE WELL Chiropractic and Pilates Center
8200 S Port Dr., Suite 106 Manhattan KS 66502
785-320-6935

PATIENT INTAKE FORM

Date: _____/_____/_____

Patient's Full Name _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone _____ Cell Phone _____ Email: _____

Male Female Date of Birth:_____/____/_____ Married Single Widowed Separated Divorced

Spouse's Name _____ Number of Children/Ages _____

How Did You Find Us?

Existing Patient, Who? _____
Physician, Who? _____
Friend, Who? _____
Office Website
Social Media (Facebook/Instagram, etc)
Google:
Other: _____
Primary Family Physician: _____
Address: _____
City and State: _____
Phone #: _____

Status: Employed Full Time Student Part Time Student Retired Unemployed Occupation:_____

Employer: _____ Employer Address: _____ Business Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Previous Chiropractic Care: Yes No If Yes, for what Problem: _____

Chiropractic Dr.'s Name: _____ City: _____ State: _____

Is Today's Visit Due To A Work-Related Injury: Yes No
Is Today's Visit Due To An Auto Accident: Yes No
Date of Injury: _____
(If yes to either questions above, please check with receptionist, additional information is needed)

Authorization and Assignment

In consideration of your undertaking to care for me, the patient, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to Live Well Chiropractic and Pilates Center the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to Live Well Chiropractic and Pilates Center for the charges made for service.
4. I authorize Live Well Chiropractic and Pilates Center to prosecute said action either in my name. I further authorize Live Well Chiropractic and Pilates Center to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts Live Well Chiropractic and Pilates Center does not collect from insurance companies, whether it be all or part of what was due, **I personally owe to Live Well Chiropractic and Pilates Center.**
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you Live Well Chiropractic and Pilates Center are **paid in full**.

PATIENT INTAKE FORM

Patient Signature: _____ Date: _____

Dear Patient, please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if Chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank You.

Present complaint(s): _____

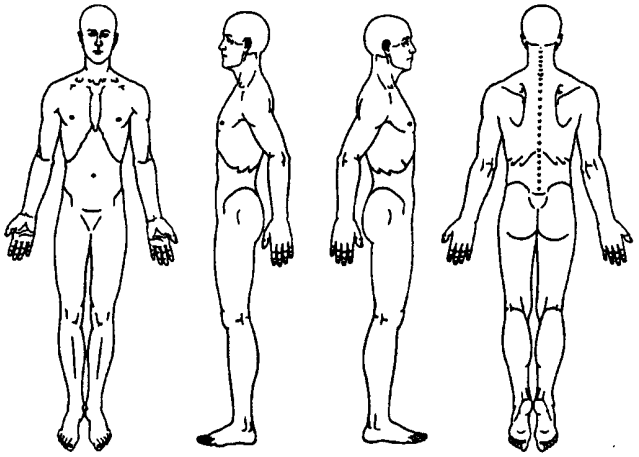
When did your symptoms begin? (Specific date if possible _____

How did your symptoms begin? (i.e. Lifting, bending, etc.. _____

In the past have you had anything similar to this? Yes No
Please explain _____

PAIN CHART

Please Mark the Areas of Pain on The Diagram Below, then Describe Your Pain(s) separately in each box.



What brings you into consult with me?

DESCRIBE YOUR PAIN
#1 Complaint
(Rate your level of Pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

Check all that apply to your #1 Complaint

Sharp	Ache	Tingling
Stabbing	Soreness	Numbness
Burning	Weakness	Dull
Shooting	Throbbing	Constricting

Other :_____
How often is this complaint present?
Constant 100% of the time Frequently 75%
Intermittent 50% Occasional 25%

DESCRIBE YOUR PAIN
#2 Complaint
(Rate your level of Pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

Check all that apply to your #3 Complaint

Sharp	Ache	Tingling
Stabbing	Soreness	Numbness
Burning	Weakness	Dull
Shooting	Throbbing	Constricting

Other :_____
How often is this complaint present?
Constant 100% of the time Frequently 75%
Intermittent 50% Occasional 25%

Check each following box that applies to your pain(s), and place the **Complaint #** next to its corresponding box :

Is your Pain:
- Increasing
- Decreasing
- Not Changing
- Varies

Was the Onset:
- Gradual
- Sudden

Pain is aggravated by:

Walking	Lifting
Sitting	Bending
Riding in a car	Stretching
Standing	Twisting
Other	

_____

Pain is improved by:

Medication	Rest
Chiropractic Adjustment	Exercise
	Therapy
	Other

_____

Family Doctor / Primary Care Physician(PCP)?

We normally keep your family doctor and/or referring physician informed regarding your care at this office.

Yes No Is it okay to inform your PCP?

Yes No Is pain affecting your ability to work or be active? **If Yes** explain: _____

Yes No Any change in bowel or bladder (bathroom) function? **If Yes** explain: _____

Yes No Any fever or chills? **If Yes** explain: _____

Yes No Any dizziness associated with symptoms? **If Yes** explain: _____

Yes No Have you experienced any unexplained weight loss, fatigue, or blood loss? **If Yes** explain:_____

Yes No Are your complaints affecting your sleep? **If Yes** explain: _____

Yes No Have you had any tests for this complaint? (i.e. X-rays, MRI, CT) **If Yes** explain: _____

Yes No Any past or recent falls / accidents / surgeries / broken bones? **If Yes** explain: _____

Yes No Have you seen any other physicians in the past 6 months? **If Yes** explain: _____

Yes No Have you had any prior treatment for this or a related complaint, including any physical therapy? **If Yes**, who and what treatment? _____

Yes No Have you ever been in the hospital or had surgery for any reason? **If Yes** explain: _____

Yes No Have you ever been in an accident? **If Yes** explain: _____

Yes No Do you smoke? **If Yes** how much? _____If you have quit smoking, when did you quit? _____

Yes No Do you consume alcohol? IF yes, how much?

What do you think is the most important thing I can do to help you achieve your goals?

What type of care are you interested in?

Pain relief only Healing of current condition Optimizing your health All three

What non-prescription medication are you taking?

Tylenol Aspirin
Ibuprofen None
Other
_____

How often? Daily Weekly Other
_____

What Prescription medication are you taking?

Anti-inflammatory Birth Control Pill Diet Pills
Pain Killers Cholesterol Meds Nerve Pills
Muscle Relaxers Insulin HRT
Blood Pressure Meds Tranquilizers Sleeping Aid
Blood Thinners None
Other

Specific names if possible: _____

FAMILY HISTORY AND HEALTH STATUS: List any diseases, disorders, or major illnesses. If deceased, from what?
(This information may help determine your familial susceptibilities to illness, disorders, etc., and help me better treat your condition.)

Mother: _____ Father: _____

Brother(s): _____ Sister(s): _____

Other: _____ Other: _____

Are you currently pregnant? Yes No

Do you have any bleeding disorders? Yes No

Explain further if yes _____

Do you have any other health concerns or diseases? (eg: heart disease, hypothyroidism, asthma, allergies, etc.)

_____

Do you have any specific dietary guidelines you follow? Gluten Free Dairy Free Vegetarian / Vegan Other:

_____

Do you feel drops in your energy levels throughout the day? □ Check box if yes, and specify when:

Do you drink Soda? **Yes** **No**
□ Check box if you drink regular soda, and include how many cans/bottles per week:
□ Check box you drink diet soda, and include how many cans/bottles per week:

_____

Do you drink coffee/tea or other caffeinated beverages? **Yes** **No**
□ Check box you drink coffee/tea, and include how much you drink per day
□ Check box you drink energy drinks, and include how many cans/bottles per day:

Yes No Do you exercise: If yes, list your most strenuous workouts, time/min, level of exertion (1 - least to 10 - most), frequency/week:
Activity:
Average duration of activity (minutes):

Days/week: __

How many glasses of water do you consume daily?
□ 1 - 3 □ 4 - 6 □ 7 - 9 □ 10 - 12 □ > 12

Social Participation (Please answer by checking the one box that best applies to you. We realize you may consider two or more statements apply, but please just check one statement which most clearly describes how your issues affect your social life.)

1) □ My social life is normal and give me no extra pain
2) □ My social life is normal but increases the degree of pain
3) □ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports.
4) □ Pain has restricted my social life and I do not go out as often
5) □ Pain has restricted my social life to my home
6) c I have no social life because of pain

WELLNESS QUESTIONS (answer for TODAY how you feel)

1. Fatigue	□ Very fresh	□ Fresh	□ Normal	□ More tired than normal	□ Always tired
2. Sleep Quality	□ Very restful	□ Good	□ Difficult falling asleep	□ Restless sleep	□ Insomnia
3. General Muscle Soreness	□ Feeling great	□ Feeling good	□ Normal	□ Increased soreness/tightness	□ Very sore
4. Stress Levels	□ Very relaxed	□ Relaxed	□ Normal	□ Feeling stressed	□ Highly stressed
5. Mood	□ Very positive mood	□ A generally good mood		□ Less interested in others and/or activities than usual	
	□ Snappiness at teammates, family, and coworkers			□ Highly annoyed, irritable, or down	