LIVINGSTON
CHIROPRACTIC & REHAB

DATE:____/____/____

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

PATIENT INFORMATION:

FULL NAME_____D.O.B.____/____/____ AGE_____Male☐ Female☐

ADDRESS_____ APT#_____ SSN_____-____-_____

CITY_____ STATE_____ ZIP_____ EMAIL_____

CELL PHONE (____)_____ HOME PHONE (____)_____

EMPLOYER'S NAME_____ OCCUPATION_____

WORK ADDRESS_____ CITY_____ STATE_____ ZIP_____

WORK PH. # (____)_____ EXT._____ DATE SYMPTOMS BEGAN ___/___/___

MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

HOW DID YOU HEAR ABOUT US?

☐ Referral: Let us know who to thank:_____
☐ Postcard
☐ Google Search: Do you remember what you searched _____
☐ Walk-in
☐ Our Website
☐ Other:_____

EMERGENCY CONTACT _____ PHONE (___)_____

AUTHORIZATIONS:

A. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits to either myself or the party who accepts the assignment.
B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I know that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company. Upon receipt, any amount authorized to be paid directly to this office will be credited to my account. However, I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also know that fees for products or professional services rendered will be immediately due and payable if I suspend or terminate my care and treatment.

Patient's Signature: _____ Date:_____

Guardian Signature: _____ Date: _____

HEALTH QUESTIONNAIRE-HISTORY

Patient's Name

E. REVIEW OF SYSTEMS

Are You Currently Suffering From Any Of The Symptoms Listed Below? If This Is A Re-Examination Mark Only New Symptoms Since Your Last Exam.

○ **None** Of The Symptoms Listed Below	○ **No New** Symptoms Since Your Last Exam

- ○ General Fatigue
- ○ Weakness
- ○ Fever (continuous)
- ○ Loss Of Sleep
- ○ Chills (continuous)
- ○ Weight Change (unplanned)
- ○ Night Sweats

- ○ Headaches
- ○ Dizziness
- ○ Fainting
- ○ Convulsions
- ○ Nervousness

- ○ Anxiety
- ○ Depression (prolonged)
- ○ Phobias (excessive fears)
- ○ Memory Loss Or Impairment
- ○ Mood Swings (excessive)

	Left	Right
Hearing Trouble	○	○
Ringing in Ears	○	○
Pain in Ears	○	○
Ear Discharge	○	○
Vision Trouble	○	○
Pain in Eyes	○	○
Eye Discharge	○	○

- ○ Nose/Sinus Pain
- ○ Excessive Drainage
- ○ Nose Bleeds (chronic)
- ○ Nasal Infections (chronic)
- ○ Absence Of Smell

- ○ Mouth Sores
- ○ Bleeding Gums
- ○ Enlarged Glands
- ○ Absence Of Taste
- ○ Abnormal Taste Sensation
- ○ Tonsillitis/Infected Tonsils
- ○ Difficulty With Swallowing

- ○ Heat/Cold Intolerance
- ○ Sugar In Urine
- ○ Goiter (enlargedThyroid gland)
- ○ Tremor (shaking)

- ○ Skin Rash
- ○ Redness Of Skin
- ○ Skin Itching
- ○ Skin Dryness
- ○ Eczema(red, inflamed skin)
- ○ Hair Changes (unplanned)
- ○ Nail Changes (unplanned)
- ○ Bruise Easily

- ○ Cough (chronic)
- ○ Wheezing (chronic)
- ○ Difficulty Breathing
- ○ Swollen Extremities
- ○ Blue Extremities
- ○ Varicosities (visible veins)
- ○ Rapid Heart Beat
- ○ Chest Pain
- ○ Heart Palpitations
- ○ Heart Murmur

- ○ Decreased Appetite
- ○ Increased Appetite
- ○ Abdominal Pain
- ○ Hemorrhoids
- ○ Excess Gas
- ○ Vomiting (excessive)
- ○ Diarrhea (excessive)
- ○ Constipation (excessive)
- ○ Heartburn/Indigestion

- ○ Painful Urination
- ○ Inability To Hold Urine
- ○ Frequent Urination
- ○ Urinary Retention
- ○ Bed-wetting
- ○ Irregular Menstruation
- ○ Painful Menstruation
- ○ Abnormal Vaginal Bleeding
- ○ Sterility
- ○ Impotence

- ○ Lumps In Breast(s)
- ○ Redness/Itching of Breast
- ○ Dimpling of Breast(s)
- ○ Discharge from Breast(s)
- ○ Breast Pain

○ Other (Please Describe)

F. HABITS/ACTIVITIES

What Are Your Current Habits?

	Never	<1	1-2	2-3	3-4	5+
Smoking (Packs Per Day)	○	○	○	○	○	○
Caffeinated Drinks (Glasses Per Day)	○	○	○	○	○	○
Alcohol Consumption (Glasses Per Day)	○	○	○	○	○	○

Drug/Substance Abuse.. ○ No ○ Yes **If Yes, Discuss With Doctor**

	Never	<1	1-2	2-3	3-4	5+
Exercise (Days Per Week)	○	○	○	○	○	○

Kinds Of Exercise You Do:

○ Walking ○ Jogging ○ Cycling ○ Swimming
○ Golf ○ Tennis ○ Strength Training
○ Other: _____

G. MEDICAL HISTORY

1. HEALTH CARE

a. Have You Ever Been To A Chiropractor? ○ Yes ○ No

b. Do You Have A Family Physician ○ Yes ○ No

Date Of Last Physical Exam: _____
Physician's Name: _____
Address: _____
Phone:( )

c. Have You Been Hospitalized In The Past? ○ Yes ○ No

Date & Reason For Hospitalization: _____

d. Have You Ever Had Surgery? ○ Yes ○ No

Date, Reason, Results Of Surgery: _____

e. Have You Ever Had A Serious Accident/Injury? ○ Yes ○ No

List Date & Describe Injury:

○ Auto: _____
○ Work-Related: _____
○ Personal: _____
○ Sports Injury: _____
○ Other: _____

f. Are You Currently Taking Any Vitamins, Minerals, Or Herbs? (List Supplements) ○ Yes ○ No

_____

g. Are You Currently Taking Any Medications? ○ Yes ○ No

For What Condition(s) Are You Taking Medication?

○ Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.): _____
○ Pain/Analgesics: _____
○ Anti-Depressants: _____
○ Muscle Relaxants: _____
○ Blood Pressure Pills: _____
○ Antibiotics: _____
○ Birth Control Pills: _____
○ Corticosteroid: _____
○ Other: _____

In The Past Have You Use Any Of The Following?

○ Birth Control Pills ○ Corticosteroid

h. Are You Allergic To Any Medications? ○ Yes ○ No

List Medications: _____

G. MEDICAL HISTORY - CONTINUED

1i. WOMEN ONLY:

	Yes	No
To Your Knowledge, Are You Pregnant?	○	○
If Pregnant In Past, Were Pregnancies Normal?	○	○
Are You Seeing An OB-GYN Regularly?	○	○

Number Of Births: ①②③④⑤ ○ Other:___

Date Of Last Exam:_____

Physician's Name:_____

Address:_____

_____ Phone:( )_____

2. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Joint Problems	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased?
Father	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	D
Mother	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	D
Brothers	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	
Sisters	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	
Children	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	

Describe Others:_____

3. Conditions Or Illnesses

Please Indicate If You Now Have or Have Had In The Past Any Of The Following Illnesses:

○ *No Current Or Previous Conditions/Illnesses*

Now Have	In Past		Now Have	In Past	
H	P	Sinus Trouble	H	P	Kidney Trouble
H	P	Hay Fever	H	P	Urinary Retention
H	P	Allergies	H	P	Frequent Urination
H	P	Asthma	H	P	Prostate Trouble
H	P	Emphysema	H	P	Arthritis
H	P	Tuberculosis	H	P	Osteoporosis
H	P	History of Infection	H	P	Scoliosis
H	P	Fever (Continuous)	H	P	Dislocated Joints
H	P	Cancer/Tumor	H	P	Spinal Disc Disease
H	P	Diabetes	H	P	Bone Fracture (list/dates):
H	P	Visual Disturbances			
H	P	Dizziness/Fainting			
H	P	Epilepsy/Seizures			
H	P	Thyroid Trouble	H	P	Mental/Emotional Difficulty
H	P	High Blood Pressure	H	P	Sex. Trans. Diseases
H	P	Low Blood Pressure	H	P	HIV
H	P	Heart Trouble	H	P	AIDS/ARC
H	P	Pacemaker	H	P	Abnormal Weight Gain
H	P	Stroke [date_____]	H	P	Abnormal Weight Loss
H	P	Aortic Aneurysm	H	P	Numbness Groin/Buttocks
H	P	Anemia	H		Other:
H	P	Rheumatic Fever			
H	P	Polio		P	Other:
H	P	Multiple Sclerosis			
H	P	Ulcer			
H	P	Liver Trouble			

H. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

1. Are You Right Or Left Handed? ○ Right ○ Left

2. Job Type

○ Retired ○ Unemployed ○ Full-Time Student

If Any Of Above Skip Rest, Sign At Patient's Signature

○ Full Time ○ Part Time ○ Temporary

○ Self-Employed ○ Other

3. During Your Work Week, You Work How Many:

Hours Per Day ①②③④⑤⑥⑦⑧⑨⑩⑪⑫

Days Per Week ①②③④⑤⑥⑦

○ Other

4. How Long Have You Been With Your Present Employer?

Years ⑩ ⑳ ㉚ ㊵ ㊿ ①②③④⑤⑥⑦⑧⑨

Months ①②③④⑤⑥⑦⑧⑨⑩⑪

5. Do Your Present Complaints Affect The Number Of Hours You Work Per Day? ○ Yes ○ No

6. What Is Your Primary Work Position and Location?

a. Work Position: ○ Seated ○ Standing ○ Other

b. Work Location: ○ Desk ○ Counter ○ Workbench ○ Other

7. What Movements Does Your Job Require?

○ Bending ○ Turning ○ Stooping

○ Twisting ○ Walking ○ Repetitive Hand Use

○ Carrying ○ Other

8. Does Your Work Include Any Of The Following Use?

○ Prolonged Computer ○ Continuous Phone

9. Does Your Job Involve Lifting?

○ Never ○ Occasionally ○ Intermittently

○ Frequently ○ Constantly

How Many Pounds? (Choose Only One) ○10 ○20 ○30 ○40 ○50 ○60 ○70 ○80 ○90 ○100+ Pounds

10. What Best Describes Your Stress Level At Work?

○ None ○ Minimal ○ Minimal To Moderate

○ Moderate ○ Moderate To Extreme ○ Extreme

11. How Do You Rate Your Physical Activity At Work?

○ Seated more than 50% of workday

Manual Labor: ○ Light ○ Light To Moderate ○ Moderate ○ Moderate To Heavy ○ Heavy

12. Do Work Activities Aggravate Your Present Complaints?

○ Yes ○ No If Yes, Explain:_____

PATIENT'S SIGNATURE _____ DATE: _____

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PLEASE MAKE NO MARKS IN THIS AREA