Living Health Chiropractic, PLLC

91 Troy Road, East Greenbush, NY 12061
Phone (518) 477-6330 Fax (518) 477-5085

Patient Information

LHC#:_____

Name _____ Date _____/_____/_____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (____) _____ Cell Phone (____) _____

Best number to reach you at: Home Work Cell (Please circle one)

Date of Birth _____ (Age) _____ Referred by _____

Social Security # _____ Email Address _____

Employer _____Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Marital Status ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed Spouse's Name _____

Number of Children _____ Names/Ages _____

Emergency Contact: _____ Phone # _____

Have you ever had Chiropractic Care? ❑Yes ❑No If yes, when, where and why? _____

_____

Primary Care Physician: Name _____

Address _____ Phone # _____

Have you been in an accident? ❑Yes ❑No If yes, was it ❑Work ❑Auto ❑Other Date _____

Nature of Accident _____

Insurance Information

Insurance Company Name _____

Policy ID# _____ Group # _____

Subscriber's Name (if different than patient) _____

Subscriber's Date of Birth _____ Subscriber's Social Security # _____

Subscriber's Employer _____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system, that have resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Patient Name _____ LHC#: _____

Loss of Wellness (Birth to Age 5)

Let's begin at birth when you may have first damaged your nervous system.

Birth to Age 5	Yes	No	Doctor Notes
1. PREGNANCY: Did your mother…			
Smoke or drink alcohol?	❑	❑	_____
Have a proper diet?	❑	❑	_____
Exercise?	❑	❑	_____
Experience any falls or injuries?	❑	❑	_____
2. BIRTH PROCESS			
Was the delivery long?	❑	❑	_____
Was the delivery difficult?	❑	❑	_____
Forceps used?	❑	❑	_____
C-section?	❑	❑	_____
Breach/cephalic?	❑	❑	_____
Home Birth?	❑	❑	_____
Hospital Birth?	❑	❑	_____
Mother given drugs during delivery?	❑	❑	_____
Was labor induced?	❑	❑	_____
Premature?	❑	❑	_____
3. GROWTH & DEVELOPMENT			
Did you ever fall out of bed?	❑	❑	_____
Were you breast-fed?	❑	❑	_____
Major childhood illnesses?	❑	❑	_____
Accidents?	❑	❑	_____
Surgeries?	❑	❑	_____
Drugs?	❑	❑	_____
Child Abuse?	❑	❑	_____
Other traumas?	❑	❑	_____

Loss of Whole Body Health (Age 5 – Present)

As you increased the layers of damage you probably began to experience symptoms.

Age 5 – Present	Yes	No	Doctor Notes
Did/do you smoke?	❑	❑	_____
Did/do you drink any alcohol?	❑	❑	_____
Diet (do you eat healthy foods?)	❑	❑	_____
Have you been in any accidents?	❑	❑	_____
Have you had any surgeries?	❑	❑	_____
Drugs? (prescription/over- the- counter)	❑	❑	_____
Jaw/Teeth problems?	❑	❑	_____

Patient Name _____ LHC#: _____

Age 5 – Present (cont.)

	Yes	No	Doctor Notes
Eye Problems?	❑	❑	_____
Hearing problems?	❑	❑	_____
Exercise regularly?	❑	❑	_____
Did/do you have occupational stress?	❑	❑	_____
Physical stress?	❑	❑	_____
Mental stress?	❑	❑	_____
Hobbies/Sports injuries?	❑	❑	_____
Other traumas/problems	❑	❑	_____

Sleeping Habits

Sleeping posture ❑ Side ❑ Stomach ❑ Back

Symptoms and Ill Health (Present State)

Finally, years of continuing damage showed up as acute or chronic symptoms.

Chief Complaint _____

Pain or problem started _____

Type of pain ❑Sharp ❑Dull ❑Throbbing ❑Numbness ❑Aching ❑Shooting ❑Burning ❑Tingling ❑Cramps ❑Stiffness ❑Swelling ❑Other _____

Does the pain radiate? ❑Yes ❑No Is the pain getting progressively worse? ❑Yes ❑No

Does the pain interfere with ❑Work ❑Sleep ❑Daily Routine ❑Recreation ❑Other _____

What activities aggravate your pain? _____

What activities lessen your pain? _____

Is the pain worse during certain times of the day? ❑Yes ❑No _____

Other symptoms: (please mark all that apply)

❑ Headaches	❑ Neck Pain	❑ Sleeping Problems	❑ Back Pain
❑ Nervousness	❑ Tension	❑ Irritability	❑ Chest Pain
❑ Dizziness	❑ Stiff Neck	❑ Pins & Needles in Legs	❑ Pins & Needles in Arms
❑ Numbness in fingers	❑ Numbness in Toes	❑ Shortness of Breath	❑ Fatigue
❑ Depression	❑ Lights bother eyes	❑ Loss of Memory	❑ Ears Ring
❑ Fever	❑ Fainting	❑ Loss of Smell	❑ Loss of Taste
❑ Diarrhea	❑ Constipation	❑ Feet Cold	❑ Hands Cold
❑ Stomach Upset	❑ Cold Sweats	❑ Loss of Balance	❑ Buzzing in Ears

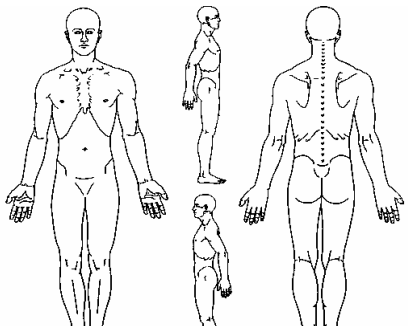
Please rate the pain on the following scale:

NO PAIN 0 - - - - - 1 - - - - - 2 - - - - - 3 - - - - - 4 - - - - - 5 - - - - - 6 - - - - - 7 - - - - - 8 - - - - - 9 - - - - - 10 ***THE WORST PAIN***

Have you been under drug or medical care for this pain? _____

How long? _____ Have you had surgery? ❑Yes ❑No Describe _____ When _____

Please indicate where you pain is on the following diagrams:



Patient Name _____ LHC#: _____

Health History – Medications – Allergies

Please mark the appropriate box to indicate if you have ever had any of the following:

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

Is there a family history of?

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❑	❑	❑	❑	❑
Mother's Side	❑	❑	❑	❑	❑

Medications: (Please list all medications that you currently take)_____

_____

_____

_____

Allergies: (Please list all allergies) _____

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most *recent* layer of Spinal and Neurological damage (Vertebral Subluxation Complex). This care usually reduces or eliminates the symptoms. Then **Reconstructive Care** begins which corrects the years of damage that occurred when there were few symptoms. And finally, chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained to you and then you'll be able to begin a course of care that fits your health goals.

Confidentiality Policy

Living Health Chiropractic, PLLC keeps all patient files in a locked cabinet which can only be accessed by authorized personnel. Likewise, all electronic data regarding our patients is kept on a secure password protected computer that can only be accessed by authorized personnel.

I understand the above policy and have ❑ accepted ❑ declined a written copy of this policy.

_____ Patient Initials

Patient Name _____ LHC#: _____

Statement of Acknowledgement of Financial Responsibility

* I understand that I will be financially responsible for any charges incurred at Living Health Chiropractic, PLLC, including copays, deductibles, rescans and charges denied or not covered by the insurance companies.
* I realize my care may be subject to pre-certification by the insurance company, and I accept any responsibility for charges which may not be approved. The insurance company will review any/all documentation submitted by Living Health Chiropractic, PLLC for review for medical necessity and base their approval/denial upon this documentation.
* Living Health Chiropractic, PLLC may seek payment from me for any services my health insurance plan determine to be not medically necessary.

_____ Patient Initials

Assignment of Benefits / Designation of Authorized Representative

I certify that I, and/or my dependent(s), have insurance coverage with the above referenced insurance carrier and I therefore assign directly to Living Health Chiropractic, PLLC or any physician working under the umbrella of Living Health Chiropractic, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I do hereby designate Living Health Chiropractic, PLLC and agent (here after referred to as my doctor), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA) and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the service(s) received from my doctor. These rights include the right to act on my behalf with respect to initial determination of claims, medical or other health care service benefits, insurance or health care reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the service received from my doctor.

_____ Patient Initials

Privacy Practices Acknowledgement

The privacy practices information is posted in the office. I can request a copy from the office if I wish. I acknowledge that I am aware of this information.

_____ Patient Initials

Signature

I state that all of the above information is true and correct to the best of my knowledge.

_____ _____/_____/_____

Patient's/Parent/Guardian Signature Date

_____

If not patient, relationship to patient