HEALTHYLIVING
CHIROPRACTIC & WELLNESS CENTER

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Onalaska, WI 54650
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www.hlconalaska.com

Last Name:_____ First Name:_____ Middle Initial:_____
Address:_____
Birthdate:___/___/___ SSN:_____ Gender: Male/ Female
Home Phone:_____ Cell Phone:_____ Work Phone:_____(optional)
e-mail:_____ I wish to receive e-mails: Y N
Occupation:_____ Employer:_____
Emergency Contact:_____Phone:_____

Complaint	**Onset**	**Quality** (ex: sharp, dull, achy)	**Radiation** Does the pain travel?	**Severity (1-10)** 1= Slight 10=Agonizing	**Timing** (Constant, Frequent, Intermittent)

What have you tried that makes your pain better?_____

What have you tried that makes you pain worse?_____

Have you had this condition in the past?_____ When?_____

Have you consulted anyone else for this condition?_____

Is this condition the result of an Trauma, Work Accident or Auto Accident?_____

What do you think would help your codition?_____

Have you seen a Chiropractor in the past? Y N If so, when was you last adjustment?_____

Please rate the following categories on a scale of 1-10. 10=I am excellent! 1= I have neglected this for a long time.

Nutrition:_____ Sleep:_____ Exercise:_____ Water Intake:_____

Stress Reduction:_____ Weight Management:_____ Avoiding toxins:_____ Anxiety:_____

<u>Circle How Your Pain Affects Your Activities of Daily Living?</u>

Sitting Standing Sit to Stand Raising arm above head Bending

Lifting	Lying Down	Dressing	Using a Computer	Caring For Family
Exercising	Driving a Car	Concentrating	Showering	Getting to Sleep
Staying Asleep	Leisure Activities	Looking over Shoulder		

Review of Systems

*Please circle if you had had these symptoms in the last **6 months.***

Headaches	Dizziness	Pins and Needles	Numbness	Anxiety
Depression	High Blood Pressure	Low Blood Pressure	High Cholesterol	Poor Circulation
Angina	Asthma	Shortness of Breath	Heartburn	Ulcer
Constipation	Diarrhea	Anorexia/Bulimia	Blurred Vision	Ringing in the Ears
Hearing Loss	Loss of Smell	Loss of Taste	Skin Cancer	Psoriasis
Eczema	Acne	Hair Loss	Rash	Sleeplessness

Current Medications/Supplements

_____

_____

_____

_____

_____

Prior Trauma/Surgery

Incident	**Date**	**Treating Physician**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Mother_____

Father_____

Grandparents_____

Children_____

Please Initial

_____I Instruct the Chiropractor to deliver the care that, in his or her best judgment, can help me in the restoration of my health. I also understand the Chiropractic Care delivered in this office is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a distinct healing art from medicine and does not

proclaim to cure any named disease or entity.

_____I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual cycle:_____

_____I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letter, or E-mails or health information to be as an extension to my care in this office.

_____I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

Printed Name_____

Signature_____ **Date:_____**

We appreciate your patience in filling out the necessary paperwork!

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