Life Long Wellness

Confidential Patient Information

Todays Date: _____

General Information

Name_____ Sex_____ Age_____

Address_____ City_____ State_____ Zip_____

Married Single Other Date of Birth _____ SSN_____

Phones: Home _____ Cell _____ Email _____

Occupation _____ Employer _____

How did you hear of our office?_____

Have you ever been to a physical therapist? **Y N** For what? _____

How often do you exercise? **Never Occasionaly Sometimes Regularly**

Why do you brush & floss your teeth? **To Prevent Decay** **To Keep Teeth/Gums Healthy**

The body has the amazing ability to heal itself. How confident are you in your body's ability to heal itself?

Not 1 2 3 4 **5** 6 7 8 9 **Fully**

Focus of Care

What are your reasons for seeking care at our office?_____

What was the initial cause?_____

When did it begin?_____ Since onset, has it gotten better or worse?_____

What makes it feel better?_____

What makes it feel worse?_____

Please check any activities that have been affected:

- ☐ Work
- ☐ Sitting
- ☐ Stretching
- ☐ Relationships
- ☐ Sleep
- ☐ Standing
- ☐ Social Life
- ☐ Exercise
- ☐ Walking
- ☐ Bending
- ☐ Recreation
- ☐ Emotions
- ☐ Other_____

Which are you interested in?

- ☐ Pain Relief
- ☐ Postural Correction
- ☐ Stress Relief
- ☐ Athletic Performance
- ☐ Wellness Care
- ☐ Other_____

How committed are you to correcting this problem? (0 - Not at all, 10 - Completely)

0 1 2 3 4 **5** 6 7 8 9 **10**

Please list any relevant medical events (surgeries, hospitilizations, treatments, etc…)_____

_____

_____

_____

Please list any family history of major medical conditions, illnesses or diseases_____

_____

_____

Please list conditions you take medication for_____

_____

_____

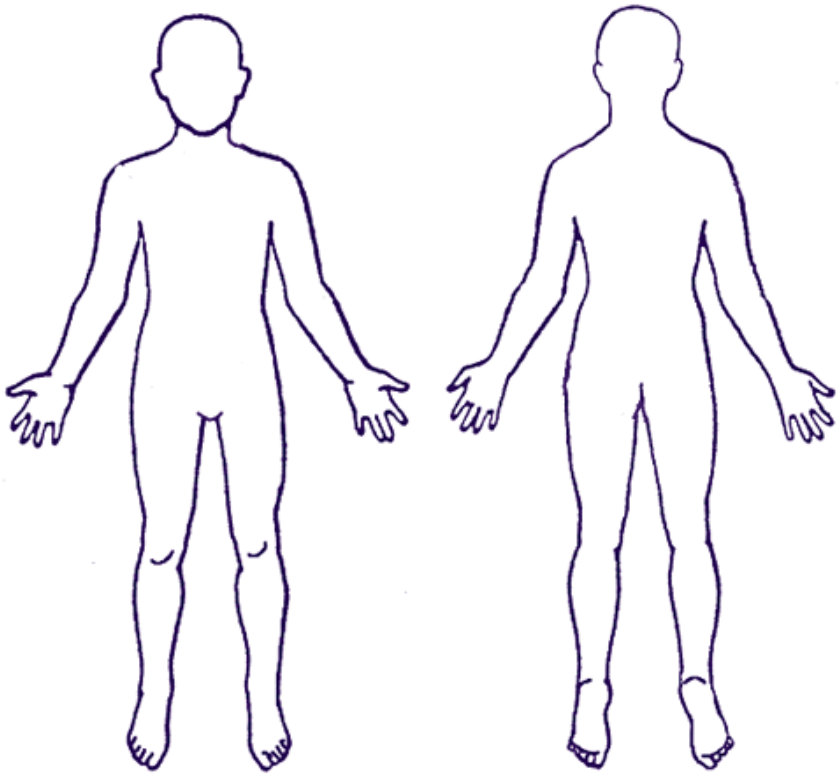
Please list any allergies_____

Please list supplements your are taking_____

_____

1) Draw your symptoms

2) Draw your face



(Front) *(Back)*

How bad is your complaint on average? (0 - No Pain, 10 - Worst Imaginable)

0 1 2 3 4 **5** 6 7 8 9 **10**

How bad is your complaint at its worst? (0 - No Pain, 10 - Worst Imaginable)

0 1 2 3 4 **5** 6 7 8 9 **10**

By signing below, I certify that the above information is true and correct and I agree to notify the doctor/staff of any changes as they occur. I authorize Life Long Wellness to obtain verification of my insurance coverage and understand that such verification is not a guarantee of payment. I understand and agree that insurance policies are an arrangement between my insurance carrier and myself. I authorize the release of any medical information necessary to process insurance claims. I also request and authorize payment of benefits to Life Long Wellness or Jason D Atkinson, DC if they accept assignment. I hereby authorize Life Long Wellness, its doctors/staff to perform chiropractic/acupuncture examination and to render treatment as they deem necessary. I understand that I am seeking holistic care and not allopathic care and that information obtained during my examination is of a holistic nature and that an allopathic, medical diagnosis will not be given. I understand that my personal and medical information are private and protected by HIPAA law and that any release of such information will require my consent and signature.

Printed Name_____

Signature of Patient (or Guardian)_____