LIFEPOINTE CHIROPRACTIC & WELLNESS CENTER
248-623-6107

DATE: _____ ID #: _____

CONFIDENTIAL PATIENT INFORMATION

Welcome to our office

PLEASE COMPLETE ALL QUESTIONS

Name: _____ Called Name: _____ Age: _____ Sex: M / F Birthdate: _____

Address: _____ City/State/Zip: _____

Cell Phone: ( )_____ Home phone: ( )_____ Social Security #: _____

Marital Status: S M D W Spouse's Name: _____

Email address: _____

Emergency Contact Name: _____ Phone: ( )_____

Children's Names/Ages: _____

How did you hear about our office? _____

IMPORTANT HEALTH INFORMATION

I am not experiencing symptoms. I am primarily interested in Wellness Care? Yes / No

What health challenges are occurring? _____

When did it begin? _____ Is it related to - Auto accident? Work injury? Personal injury? None of these?

Is the condition getting progressively worse? Y / N Constant? Y / N Comes and goes? Y / N

Is the condition interfering with your: Work? Sleep? Daily Routine? Other: _____

Height: _____ Weight: _____

Have you previously had Chiropractic care? Y / N When? _____

List all medications you are currently taking: _____

_____

List all supplements you are currently taking: _____

_____

List any surgeries/illnesses you have had? _____

Have you ever been diagnosed with cancer? SELECT If yes, what type? _____

Is there a chance you may be pregnant? SELECT Date of last menstrual period: _____

Please continue to next page

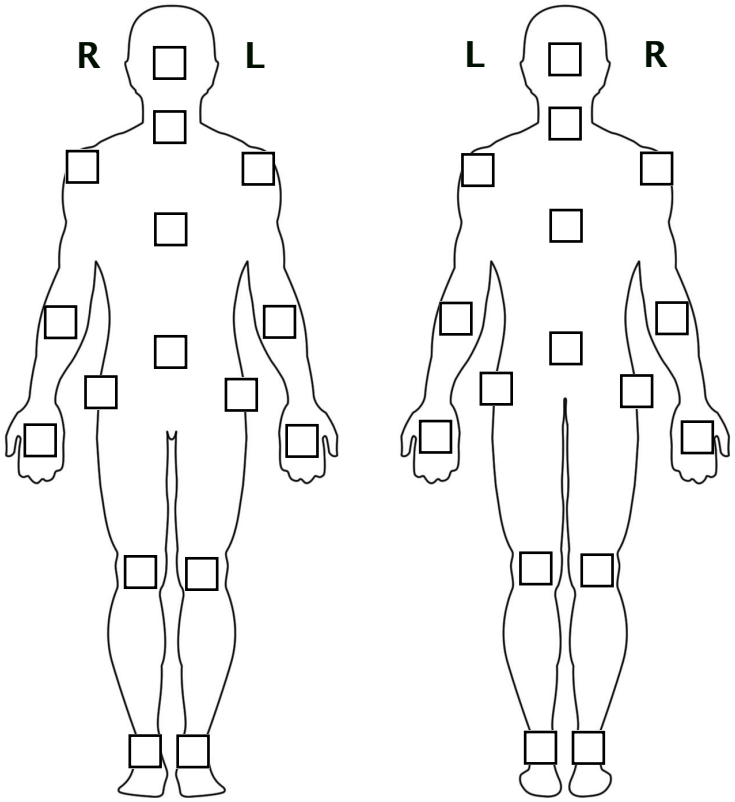
Do you now or have you ever suffered from (select all that apply):

Low back pain ☐	Dizziness ☐	Weight loss or gain ☐	Swelling ☐	Seizures ☐
Mid back pain ☐	Asthma ☐	Vision Changes ☐	Heartburn ☐	Depression ☐
Neck pain ☐	Headaches ☐	Glaucoma ☐	Urinary urgency ☐	Memory loss ☐
Shoulder pain ☐	Gas/bloating ☐	Cataracts ☐	Blood in urine ☐	Emotional stress ☐
Pain or clicking jaw ☐	Blood pressure High ☐ / Low ☐	Ringing in ears ☐	Incontinence ☐	Thyroid condition ☐
Arm/leg pain ☐	Ear aches ☐	Heart disease ☐	Joint redness/swelling ☐	Heat/cold intolerance ☐
Numbness/tingling ☐	Elimination problems ☐	Chest pain ☐	Arthritis ☐	Vasectomy/hysterectomy ☐
Digestive disorders ☐	Fatigue ☐	Heart palpitations ☐	Scoliosis ☐	Other: ☐
Allergies ☐	Loss of sleep ☐	Shortness of breath ☐	Skin rashes ☐	
Sinus trouble ☐	Menstrual problems ☐	Blood clots ☐	Fainting ☐	

Do you have a family history of disease? Please list here: _____

_____

Please mark all problem areas on the figures



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FINANCIAL INFORMATION

Do you have health insurance? SELECT With whom? _____

If yes, what is your relationship to the insured? SELF SPOUSE CHILD OTHER _____

(If the insured is someone other than yourself, please complete the information below).

Insured's Full Name: _____ Insured's Date of Birth: _____

Financial Responsibility: I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Lifeppointe Chiropractic Center will prepare any necessary reports and forms to assist me in making collections from the insurance company. HOWEVER, I clearly understand and agree that I am personally responsible for any payment.

CONSENT FOR TREATMENT/TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.
Chiropractic has only one goal: to eliminate misalignments within the spinal column that interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. Our chiropractic method of correction is specific adjustments of the spine. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, the undersigned, a patient in this office, hereby authorize LIfepointe Chiropractic Center to administer treatment as necessary, if needed, within the lawful scope of chiropractic. I also certify that no guarantee or assurance has been made to the results that may be obtained. I have read and fully understand the above statements, and accept chiropractic care on this basis.
Consent for a minor (if applicable): I, the undersigned, hereby authorize Lifepointe Chiropractic Center to administer treatment as necessary, if needed, within the lawful scope of Chiropractic to my child
(Name: _____).

NOTICE OF PRIVACY PRACTICES

I understand the posted "Notice of Privacy Practices for Protected Health Information" describing how my medical information may be used and disclosed, and how I can get access to this information. (A copy of this document is available to me at any time.)

The above information is true and accurate to the best of my knowledge, and I understand and agree to the statements above.

Patient/Guardian signature: _____ Date: _____