WELCOME

Date: _____

Patient Information

Name _____

Email address: _____

Mailing Address: _____ City_____ State_____ Zip _____

Phone# (H). _____ (W) _____ (Other) _____

Preferred method of contact ☐ Phone ☐ Email ☐ Patient Portal **Preferred Language** _____

Date of Birth: _____ ☐ Male ☐ Female SS#: _____

Sex: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Race ☐ Caucasian ☐ African American ☐ Asian ☐ Native American

☐ Latin American ☐ Other: _____

Ethnicity ☐ Hispanic ☐ Latino ☐ Non-Hispanic/ Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone#: _____

Phone#: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other _____

Has it been reported? ☐ Yes ☐ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B.: _____

Relationship to patient (if other than self): _____ Phone# _____

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (Insured Patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMP ANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAY ABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE(X) _____ DATE _____

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Phone: 410-216-9180 Fax: 410-216-9669

Health History

Who is your primary care physician? (Doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Neck Pain/Stiffness	☐ Pins/Needles in Arms	☐ Light Bothers Eyes	☐ Sudden Weight Loss	☐ Nausea
☐ Back Pain/Stiffness	☐ Pins/Needles in Legs	☐ Depression	☐ Loss of Taste	☐ Cold Feet
☐ Arm/Hand Pain	☐ Fatigue	☐ Nervousness	☐ Loss of Memory	☐ Chest Pain
☐ Leg/Knee Pain	☐ Sleeping Difficulties	☐ Tension	☐ Jaw Problems	☐ Fever
☐ Headaches	☐ Loss of Smell	☐ Cold Sweats	☐ Constipation	☐ Fainting
☐ Dizziness	☐ Allergies	☐ Stomach Problems	☐ Shortness of Breath	
☐ Asthma	☐ Blurred Vision	☐ Night Pain	☐ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

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

Are you currently under drug and/or medical care? Yes No If yes, explain _____

_____

Please list any surgeries and/or hospitalizations you have had **(type & date):** _____

_____

_____

Please list any allergies:_____

_____

Is there a family history of any of the following conditions? **(Indicate family member including parents, grandparents & siblings)**

Heart Disease _____ Diabetes _____

Cancer _____ Arthritis _____ Other _____

Do you exercise: ☐ Never ☐ Daily ☐ Weekly ☐ Walks ☐ Runs ☐ Swims

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light ☐ Labor ☐ Heavy ☐ Labor

What is your daily/weekly intake of the following?

Caffeine ____ cups/day Alcohol ____ drinks/week Cigarettes ___ packs/day never smoked _____

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

☐ I choose to receive a receipt of my clinical summary after each visit.

SIGNATURE (X) _____ DATE _____

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NEUROLOGICAL /MRI/VASCULAR PATIENT QUESTIONNAIRE

Name: _____Date:_____ DOB: _____

For any YES answer, please include details

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? ☐No ☐Yes
   Comment:_____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? ☐No ☐Yes
   Comment: _____
3. Do your hands or arms fall asleep regularly? ☐No ☐Yes
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? ☐No ☐Yes
   Comment: _____
5. Do you suffer from a loss of handgrip strength? ☐No ☐Yes
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? ☐No ☐Yes
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? ☐No ☐Yes
   Comment: _____
8. Do our legs or feet fall asleep regularly? ☐No ☐Yes
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? ☐No ☐Yes
   Comment: _____
10. Do you suffer from cold hands or feet's? ☐No ☐Yes
    Comment: _____
11. Do have frequent falls or find that you trip over your feet while walking? ☐No ☐Yes
    Comment: _____
12. Do you suffer from headaches? If yes, how often, how severe, what has been tried? ☐No ☐Yes
    Comment: _____
13. Have you tried any medications such as anti-inflammatory? ☐No ☐Yes
    If yes, what kind of medication?
14. Have you tried any Physical Therapy or Chiropractic treatments before? ☐No ☐Yes
    If yes: When? For how long? What kind?
15. Have you had an MRI? ☐No ☐Yes
    If yes: When? Who ordered it? What was it ordered for?
16. Have you used any splint or braces or other prescribed treatment by an MD? ☐No ☐Yes
    If yes: When? What kind? Who ordered it?
17. If you have tried any treatment or medications, did this make your problem better? ☐No ☐Yes
    Comment: _____

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Review of Systems

Name _____ Date : _____ DOB: _____

Please mark if you have experienced any of these symptoms within the last month:

Y	N		
		Neurological	
☐	☐	Migraines	
☐	☐	Headaches	
☐	☐	Slurring of Speech	
☐	☐	Ringing in Ear	
		Ear/Nose/Throat	
☐	☐	Altered taste/smell	
☐	☐	Night Blindness	
☐	☐	Sore Throat	
☐	☐	Gingivitis	
☐	☐	Nose Bleeds	
		Cardiovascular	
☐	☐	Chest Pain	
☐	☐	Palpitations-racing Heart Beat	
☐	☐	Swelling in hands/feet	
☐	☐	Anemia	
		Respiratory	
☐	☐	Recurrent Respiratory Infections	
☐	☐	Asthma	
☐	☐	Chest Congestion	
☐	☐	Wheezing	
☐	☐	Frequent Sneezing	
		GI	
☐	☐	Stomach Pains or Cramping	
☐	☐	Constipation	
☐	☐	Reflux or Heartburn	
☐	☐	Bloating	
☐	☐	Gas	
☐	☐	Nausea or Vomiting	
		Musculoskeletal	
☐	☐	Joint Pain	
☐	☐	Arthritis	
☐	☐	Chronic Pain	
☐	☐	Muscle Aches	

Y	N		
		Skin	
☐	☐	Eczema	
☐	☐	Dermatitis	
☐	☐	Excessive Sweating	
☐	☐	Rashes	
☐	☐	Brittle Nails	
☐	☐	Hair Loss	
☐	☐	Easy Bruising	
☐	☐	Increased Bleeding	
☐	☐	Numbness/tingling	
		Genitourinary	
☐	☐	Uterine Fibroids	
☐	☐	Ovarian Cysts	
☐	☐	Cancer (breast, ovarian, prostate, uterine)	
☐	☐	Prostate Problems	
		Emotional/Mental	
☐	☐	Depression	
☐	☐	Anxiety	
☐	☐	Mood Swings	
☐	☐	Irritability	
☐	☐	Memory Loss	
☐	☐	Confusion	
		Energy	
☐	☐	Fatigue	
☐	☐	Hyperactivity	
☐	☐	Restlessness	
☐	☐	Insomnia	
☐	☐	Decreased Libido	
☐	☐	Stress	
		Weight	
☐	☐	Decreased Appetite	
☐	☐	Weight Gain	
☐	☐	Inability to Lose Weight	
☐	☐	Food Cravings	
☐	☐	Binge Eating	
☐	☐	Water Retention	

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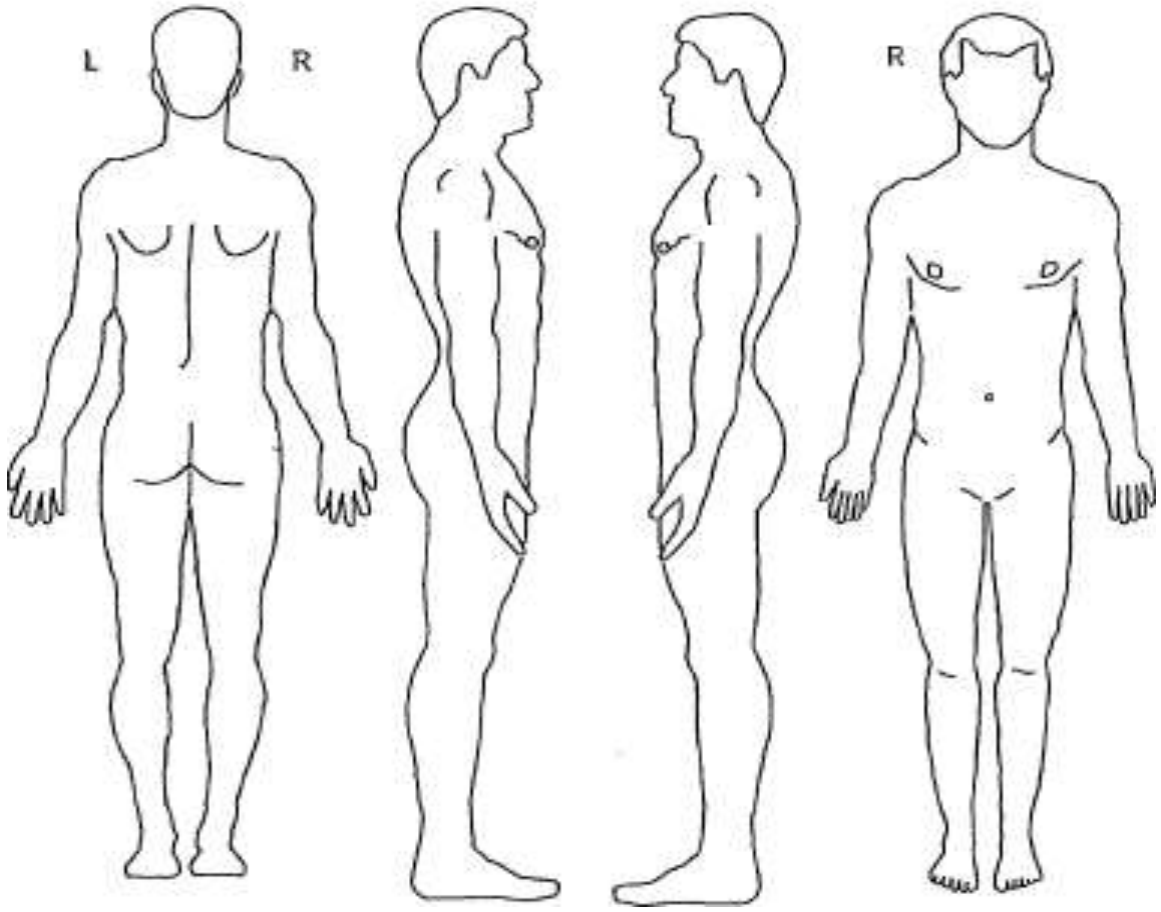
Pain Drawing

Name: _____ Date: _____ DOB: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness -------	Pins & 0000000	Burning xxxxxxxxx	Stabbing /////////	Aching ((((((
-------	Needles 0000000	Pain xxxxxxxx	pain /////////	pain ((((((



Visual Analogue Scale

Please mark on the line the pain level that most accurately represents your pain:

NO PAIN:	0	1	2	3	4	5	6	7	8	9	10 UNBEARABLE PAIN
a) Right Now:----	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 _____
b) Average Pain-	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 _____
c) At Best-------	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 _____
d) At Worst----	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 _____

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Short-Form McGill Pain Questionnaire

Ronald Melzack

Name:_____Date:_____DOB:_____

Instruction: Please a check mark in the appropriate box which describe your pain test

		NONE (0)	MILD(1)	MODERATE(2)	SEVERE (3)
1	Throbbing	☐	☐	☐	☐
2	Shooting	☐	☐	☐	☐
3	Stabbing	☐	☐	☐	☐
4	Sharp	☐	☐	☐	☐
5	Cramping	☐	☐	☐	☐
6	Gnawing	☐	☐	☐	☐
7	Hot-burning	☐	☐	☐	☐
8	Aching	☐	☐	☐	☐
9	Heavy	☐	☐	☐	☐
10	Tender	☐	☐	☐	☐
11	Splitting	☐	☐	☐	☐
12	Tiring-exhausting	☐	☐	☐	☐
13	Sickening	☐	☐	☐	☐
14	Fearful	☐	☐	☐	☐
15	Punishing-cruel	☐	☐	☐	☐

Please rate your overall pain level on the following line by placing a mark on the line which best matches your pain level.

NO Pain _____ WORST POSSIEBLE PAIN

PPI (Present Pain Intensity)--Please rate your PPI (circle the appropriate number):

0 No pain
1 Mild
2 Discomforting
3 Distressing
4 Horrible
5 Excruciating

From Melzack R. The short-form McGill Pain Questionnaire. Pain 1987;30:l 91-197

The descriptors 1-11 represent the sensory dimension of pain. Descriptors 12-15 represent the affective dimension. Each descriptor is ranked on an intensity scale of O = none, 1 = mild, 2 = moderate, 3 = severe. Th e Present Pain Intensity (PPI) of the standard long-form MPQ and the visual analog Scale are also included to provide overall pain intensity scores.

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ATTENTION NEW PATIENTS

Name:_____Date:_____DOB:_____

For your first visit please list on the back of this sheet:

1) Current medications including dosage and frequency as well as daily supplements

_____

2) List your primary care physician and all other healthcare providers overseeing your care.

_____

Your cooperation makes it possible for us to better serve you and ensure a quality comprehensive visit.

Thank You,

Living Health Integrative Medicine

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Name:_____Date:_____DOB:_____

Medication List

	Medicine	Dose	Frequency	Started (mon/yr)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

List of Doctors

Primary Care: _____
Endocrinologist: _____
Cardiologist: _____
Gastroenterologist: _____
Physiatrist: _____
Rheumatologist: _____
Oncologist: _____
Psychiatrist: _____
Psychologist: _____
Other: _____

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Informed Consent to Care

Name:_____Date:_____DOB:_____

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. We do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____

Patient Signature **Date**

Prior to receiving diagnostic testing, rehabilitation, physical therapy or chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if these treatments are needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic or physical therapy and give consent to the examinations that the doctor deems necessary, and to the chiropractic care, including spinal adjustments, as reported following my assessment.

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per twenty million cervical spine (neck) adjustments, may be a vertebral artery injury that could lead to stroke.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

_____

Patient Signature **Date**

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Name:_____Date:_____DOB:_____

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____ _

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____

_____

_____

Date of last menstrual period: _____

_____ _____

Patient Signature Date

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Name:_____Date:_____DOB:_____

I acknowledge that I have reviewed the Notice of Privacy Practices of Living Health Integrative Medicine. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

_____ _____

Signature of Patient/Parent/Guardian **Date**