Welcome to Lavan Family Chiropractic!

Patient's Information

Thank you for choosing Lavan Family Chiropractic for your chiropractic and wellness needs. Please complete this form in blue or black ink and print clearly. If you have any questions or concerns in completing the intake forms, do not hesitate to ask for assistance.

Name: ____ Social Security #: ______-____-______ Date of Birth: ___/___/___

Address: ____ City: ______________________ State: _____ Zip code: ________

Sex: ❑ Female ❑ Male E-mail: ____

Home phone: (_____)__________________ Cell phone: (_____)_________________ Work phone: (_____)_________________

Preferrence to receive appointment reminders & communications via: ❑ E-mail ❑ Home phone ❑ Work phone ❑ Cell phone

❑ Married ❑ Widow(er) ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient employer/school: ____ Occupation: ________________________________

Employer/school Address: ______________________________ City: ___________________ State: _____ Zip code: ________

Spouse or parent's name: ____________________________ Employer: ___________________ Work phone: (_____)___________

Who may we thank for referring you to us? ____

Person to contact in case of emergency: ____ Phone: (_____)_________________

Responsible Party

Person responsible for account: ______________________________ Social security #: _____-____-_____ Date of Birth:___/__/___

Relationship to patient: ____ Phone: (_____)________________

Address: ____ City: ______________________ State: _____ Zip code: ________

Name of employer: ____ Phone: (_____)_________________

Insurance Information

Insurance company name: ____ Phone: (_____)_________________

Name of insured person (if other than patient): ____

Relationship of insured to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance policy number: ______________________________________ Insurance group number: _________________________

Insurance policy: ❑ Health ❑ Medicare ❑ Automobile ❑ Worker's compensation

Claim number (if accident/injury): ____ Date of accident or injury: ___/___/___

Name of insurance case worker (if accident/injury): _____________________________________ Phone: (_____)________________

Accident/injury is related to: ❑Employment ❑Automobile ❑Other ______________________________________

Daily Habits

What type of exercise do you perform on a daily basis? ❑None ❑ Light ❑ Moderate ❑ Heavy Type: ______________

What do your daily work habits include? ____

What vitamins/nutritional supplements do you currently take? ____

Do you smoke? ❑ Never ❑ Former smoker ❑ Occasional smoker ❑ Current smoker

Do you drink alcoholic beverages? ❑No ❑Beer ❑Wine ❑Liquor How much per day? _______ How much per week? _______

How many caffeinated beverages do you consume daily? __________________ Type: ______________________________

How would you rate your overall health? ❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

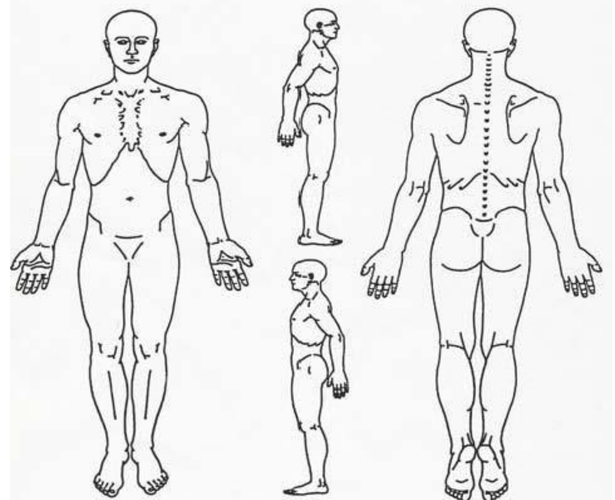
Symptoms

Reason for visit: ______________________________

When did you first notice your symptoms? ______________________________

How do you think your symptoms began? ______________________________

____



Circle on the drawings to the right where you have pain/symptoms: --->

How often do you experience your symptoms?

❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Infrequently (1-25% of the time)

How are your symptoms changing with time?

❑ Getting worse ❑ Staying the same ❑ Getting better

Type of pain: ❑ Sharp ❑ Shooting ❑ Burning ❑ Throbbing
❑ Dull ❑ Achiness ❑ Cramps ❑ Swelling
❑ Tingling ❑ Stiffness ❑ Other: ______________

Rate the severity of your current pain. Circle one. (1 = discomfort to 10 = severe pain) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

What aggravates your condition? ______________________________

What makes your condition better? ______________________________

What treatment have you received for your condition?

❑ Medication ❑ Surgery ❑ Chiropractic ❑ Physical therapy ❑ Massage ❑ None ❑ Other ______________

How much has your condition interfered with your work and social activities?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

Do you consider your condition to be severe? ❑ Yes ❑ Yes, at times ❑ No

What concerns you the most about your condition? ______________________________

What does it prevent you from doing? ______________________________

Health History *Check conditions which are applicable and indicate (C)currently and/or (P)past:* ______________

❑ Headaches
❑ Neck pain
❑ Upper back pain
❑ Mid back pain
❑ Low back pain
❑ Shoulder pain
❑ Elbow/arm pain
❑ Wrist pain
❑ Hand pain
❑ Hip pain
❑ Upper leg pain
❑ Knee pain
❑ Ankle/foot pain
❑ Jaw pain
❑ Joint pain/stiffness
❑ AIDS/HIV
❑ Alcoholism
❑ Allergy shots
❑ Anemia

❑ Anorexia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Blood disorder
❑ Breast lump
❑ Bronchitis
❑ Bulemia
❑ Cancer
❑ Cataracts
❑ Chemical dependency
❑ Chicken pox
❑ Depression
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Fractures
❑ Glaucoma
❑ Goiter

❑ Gonorrhea
❑ Gout
❑ Heart disease
❑ Hepatitis
❑ Hernia
❑ Herniated disc
❑ Herpes
❑ High cholesterol
❑ Kidney disease
❑ Liver disease
❑ Measles
❑ Migraines
❑ Miscarriage
❑ Mononucleosis
❑ Multiple sclerosis
❑ Mumps
❑ Osteoporosis
❑ Pacemaker
❑ Parkinson's disease

❑ Pinched nerve
❑ Pneumonia
❑ Polio
❑ Prostate problems
❑ Psychiatric care
❑ Prosthesis
❑ Rheumatoid arthritis
❑ Scarlet fever
❑ Stroke
❑ Thyroid problem
❑ Tonsillitis
❑ Tuberculosis
❑ Tumor/growth
❑ Typhoid fever
❑ Ulcers
❑ Whooping cough
❑ Other: __________
____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

List any surgeries/hospitalizations you have had and dates which they occurred: ______________________________

____

List any traumas/motor vehicle accidents/fractures you have had and dates which they occurred: ______________________________

____

Health History, continued

Please list all medications you are currently taking: ____________________

____

Allergies: ____________________

Family History

Indicate if you have any family members with a history of the following:

❑ Rheumatoid arthritis ❑ Diabetes ❑ Lupus ❑ Cancer ❑ Thyroid condition
❑ Heart Problems ❑ Stroke ❑ Seizures ❑ ALS ❑ Other: ____________

Motor Vehicle Accident *(if applicable)*

Date of accident: ___/___/______ Time of accident: ____________AM/PM

How and where did the accident happen? ____________________

Where were you sitting at the time of the accident? ____________________

Please mark the following that apply at the time of the accident:

❑ Wearing seat belt ❑ Airbag deployed ❑ Body hit interior of car
❑ Ejected from vehicle ❑ Lost consiousness ❑ Unaware of impending collision
❑ Aware of impending collision and relaxed ❑ Aware of impending collision and tightened up

What happened after the accident?

❑ Police arrived ❑ Ambulance arrived ❑ Taken by ambulance to hospital ❑ Police report written
❑ Refused treatment ❑ Drove to hospital ❑ Went to doctor's office ❑ Other: ____________

Immediately after the accident, where did you feel pain/symptoms? ____________________

Currently where do you feel pain/symptoms? ____________________

Other treatment received for this accident: ____________________

Worker's Compensation Injury *(if applicable)*

Date of injury: ___/___/______ Time of injury: ____________AM/PM

How and where did the injury happen? ____________________

What happened after the injury?

❑ Continued working ❑ Stopped working ❑ Notified supervisor ❑ Incident report written
❑ Drove to hospital ❑ Went to doctor's office ❑ Received no treatment ❑ Other: ____________

Immediately after the injury, where did you feel pain/symptoms? ____________________

Currently where do you feel pain/symptoms? ____________________

Are you currently working? ❑ Yes, without restrictions ❑ Yes, with restrictions ❑ No

Other treatment received for this injury: ____________________

Patient Payment Agreement

Our policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made with the doctor. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge; and I understand it is my responsibility to inform this office of any changes to my health record.

Signature ______________________________ Date ____________________