CHOOSE LIFE
WELLNESS CENTER

New Patient Paperwork

PERSONAL INFORMATION

(PLEASE PRINT CLEARLY) **Today's Date** _____

Name: _____ **S.S. #:** _____

Marital Status: ☐ S ☐ M ☐ W ☐ D **Date of Birth:** _____

Age: _____ ☐ Male ☐ Female **Height:** _____ **Weight:** _____

Address: _____ **Home Tel #** _____

_____ **Cell #** _____

City State Zip code

Drivers License #: _____ **State:** _____

Occupation: _____ ☐ Full Time ☐ Part Time

Employer: _____ **Work #** _____

Emergency Contact: _____ **Phone #** _____

E-Mail Address: _____

INSURANCE INFORMATION

Please Provide A Picture ID and Your Health Insurance Card To The Front Desk

Health Insurance Company: _____

Policy Number: _____ **Group Number:** _____

IF NAME IS DIFFERENT FROM POLICY HOLDER (Policy Holder Is: Parent/Spouse)

Policy Holder's Name: _____ **S.S. #:** _____

Policy Holder's Date of Birth: _____ **Age:** _____ ☐ Male ☐ Female

Address: _____ **Home Tel #** _____

_____ **Cell #** _____

City State Zip code

Were you referred to this office? ☐ Yes ☐ No

If yes, whom do we need to thank? _____

If no, how did you find out about our office? _____

Choose Life Wellness Center
2560 SR 50, Unit 106
Clermont, FL. 34711

Please List Each of Your Complaints/Concerns SEPARATELY And in ORDER of PRIORITY

1) Chief Complaint: _____

What do you believe may be the cause of your complaint? _____

How long have you had this condition? _____

What makes your condition feel worse? _____

What makes it feel better? _____

The pain is: ☐ **Constant** ☐ **Comes and goes** ☐ **Other** _____

The pain is worse in the: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Other** _____

How much pain, on a scale of 0 to 10 (0 is no pain and 10 is the worst pain ever) are you having? _____

What kind of pain are you having? (Sharp, dull, etc…) _____

Is the pain radiating? ☐**Yes** ☐**No** **If yes, where does the pain radiate into?** _____
What activity is difficult to do now because of your symptom?_____

2) Additional complaint: _____

What do you believe may be the cause of your complaint? _____

How long have you had this condition? _____

What makes your condition feel worse? _____

What makes it feel better? _____

The pain is: ☐ **Constant** ☐ **Comes and goes** ☐ **Other** _____

The pain is worse in the: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Other** _____

How much pain, on a scale of 0 to 10 (0 is no pain and 10 is the worst pain ever) are you having? _____

What kind of pain are you having? (Sharp, dull, etc…) _____

Is the pain radiating? ☐**Yes** ☐**No** **If yes, where does the pain radiate into?** _____
What activity is difficult to do now because of your symptom?_____

3) Additional complaint: _____

What do you believe may be the cause of your complaint? _____

How long have you had this condition? _____

What makes your condition feel worse? _____

What makes it feel better? _____

The pain is: ☐ **Constant** ☐ **Comes and goes** ☐ **Other** _____

The pain is worse in the: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Other** _____

How much pain, on a scale of 0 to 10 (0 is no pain and 10 is the worst pain ever) are you having? _____

What kind of pain are you having? (Sharp, dull, etc…) _____

Is the pain radiating? □Yes □No If yes, where does the pain radiate into? _____
What activity is difficult to do now because of your symptom?_____

4) Additional complaint: _____

What do you believe may be the cause of your complaint? _____

How long have you had this condition? _____

What makes your condition feel worse? _____

What makes it feel better? _____

The pain is: □ Constant □ Comes and goes □ Other _____

The pain is worse in the: □ Morning □ Afternoon □ Evening □ Other _____

How much pain, on a scale of 0 to 10 (0 is no pain and 10 is the worst pain ever) are you having? _____

What kind of pain are you having? (Sharp, dull, etc…) _____

Is the pain radiating? □Yes □No If yes, where does the pain radiate into? _____
What activity is difficult to do now because of your symptom?_____

Is there any additional information that the doctor should know? □Yes □No

_____

_____

_____

_____

What have you done for your complaints? _____

□I followed up with doctor: Name: _____ **Date:** _____

Treatment: _____

□I followed up with other: Name: _____ **Date:** _____

Treatment: _____

□I went to hospital/clinic: Name: _____ **Date:** _____

At the hospital/clinic I had:
□ X-Rays □ CT scan □ MRI □ Prescription medication
□ Other _____

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Posture Questions:

Abnormal postural habits are caused by a lifetime of stress and trauma that have misaligned the vertebrae of your spine. When the bones of the spine [vertebrae] are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations. These Subluxations cause stress to your nerves and will weaken and distort the overall structure of your spine. The result is a weakened and misaligned POSTURE. The most common postural distortion is called Anterior Head Translation, which is a "hunched forward" posture starting in the neck and moving down your spine, weakening your overall posture. Please check any health issues you may be experiencing or have experienced in the past. This will give us an indication of the overall health and alignment of your spine

Cervical Spine (neck)

Postural distortions from Subluxations in your neck will weaken the nerves into your arms, hands, and head. Do you experience...?

- ☐ Neck Pain
- ☐ Headaches ♋Sinusitis
- ☐ Dizziness
- ☐ Disc problems
- ☐ Allergies/Hay fever
- ☐ Tension/ Nervousness
- ☐ Hearing disturbances/ Ringing
- ☐ Arm/Hand Numbness
- ☐ Pain shoulder/arm/hand
- ☐ Visual Disturbances
- ☐ Recurrent Colds/Flu
- ☐ Coldness in hands
- ☐ Low energy/ fatigue
- ☐ Weakness in grip
- ☐ Thyroid conditions
- ☐ TMJ/Pain/Clicking
- ☐ Changes in weight

Thoracic Spine (upper-back)

Postural distortions from Subluxations in the upper back will weaken the nerves to the heart and lungs. Do you experience...?

- ☐ Heart Palpitation
- ☐ Recurrent lung infection
- ☐ Bronchitis
- ☐ High Blood Pressure
- ☐ Asthma/wheezing
- ☐ Tachycardia
- ☐ Shortness of Breath
- ☐ Heart Attack/Angina
- ☐ Pain on deep breathing

Thoracic Spine (mid-back)

Postural distortions from Subluxations in the mid back will weaken the nerves in your ribs, chest, and abdomen. Do you experience...?

- ☐ Mid-back pain
- ☐ Hypoglycemia
- ☐ Reflux
- ☐ Pain into ribs/chest
- ☐ Nausea
- ☐ Indigestion/ Heartburn
- ☐ Ulcers/ Gastritis
- ☐ Tired/irritable after eating or when hungry

Lumbar Spine (low back)

Postural distortions from Subluxations in the low back will weaken the nerves in your legs, feet, and pelvic area. Do you experience...?

- ☐ Low back Pain
- ☐ Muscle cramps in legs/feet
- ☐ Constipation
- ☐ Pain to hips/legs/feet
- ☐ Weakness to hips/legs/feet
- ☐ Recurrent bladder infection
- ☐ Numbness leg/feet
- ☐ Menstrual irregular/Cramping
- ☐ Sexual Dysfunction
- ☐ Coldness to legs/feet
- ☐ Frequent/Difficult urinating
- ☐ Disc Problems

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PAST MEDICAL HISTORY

Previous Accidents/injuries	Date	Resolved
1		☐ Yes ☐ No
2		☐ Yes ☐ No
3		☐ Yes ☐ No

Hospitalizations	Date	Resolved
1		☐ Yes ☐ No
2		☐ Yes ☐ No
3		☐ Yes ☐ No
Surgeries Performed	**Date**	**Resolved**
1		☐ Yes ☐ No
2		☐ Yes ☐ No
3		☐ Yes ☐ No

I also have a past medical history of:

☐ TMJ	☐ Vertigo	☐ Allergies	☐ Memory Loss	☐ High Blood Pressure
☐ Fractures	☐ Anemia	☐ Migraine	☐ Loss of Vision	☐ Diabetes
☐ Headaches	☐ Epilepsy	☐ Digestive	☐ Eating Disorder	☐ Heart/Cardiac
☐ Sinus	☐ Hearing	☐ Fractures	☐ Kidney Problems	☐ Cholesterol
☐ Liver	☐ Prostate	☐ Gallbladder	☐ Ringing of the ears	☐ Lung/Pulmonary
☐ Ulcers	☐ Arthritis	☐ Hyperactive	☐ Learning Disability	☐ Stroke/CVA or TIA
			☐ Depression/Anxiety	☐ Cancer

☐ Other: _____

Have you been under Chiropractic care in the past? ☐ Yes ☐ No

If yes, Doctor's Name: _____

Address: _____ **Number:** _____

_____

When was the last time you were seen? **Date:** _____

Month / Day / Year

What were you being treated for? _____

Presently under care of your private medical physician for the above medical history: ☐ Yes ☐ No

Presently on RX/prescription medications for the above medical history: ☐ Yes ☐ No

Have you notified your private medical physician for your recent complaint: ☐ Yes ☐ No

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ALLERGIES TO MEDICATIONS: □ Yes □ No

If yes, please list all: _____

PERSCRIPTION MEDICATIONS: □ Yes □ No

If yes, please list all: _____

_____

OVER THE COUNTER MEDICATION: □ Yes □ No

If yes, please list all: _____

FAMILY/SOCIAL HISTORY

Mother's History: □High Blood Pressure □Diabetes □Heart Problems
□Lung Problems □Cancer □Osteoporosis/Osteoporoses
□CVA/Strokes □Other _____

Father's History: □High Blood Pressure □Diabetes □Heart Problems
□Lung Problems □Cancer □Osteoporosis/Osteoporoses
□CVA/Strokes □Other _____

Do you drink alcohol: □Yes □No
If yes, how often: _____

Do you use tobacco: □Yes □No
If yes, how often: _____

Do you use recreational drugs: □Yes □No
If yes, how often: _____

Do you exercise: □Yes □No

If yes, I work out _____ per week

□Walk _____ miles □Run _____ miles □Bicycle _____ miles
□Cardio Training □Weight Training □Other: _____

WORK STATUS

□I am unemployed □I am Disabled
□I work Full-time _____ hours per week □Part-time _____ hours per week

Occupation: _____

Other: _____

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Our office is dedicated to achieving the goal of total lasting health for our patients.

To better help you achieve this we need to understand your commitment towards being healthy.

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). The doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief Care**

Relief Care is the care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

☐ **Corrective Care**

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

☐ **Check here if you want the doctor to select the type of care appropriate for your condition**

Patient Acknowledgement

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future.

Signature: _____ **Date:** _____

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REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures: I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Choose Life Wellness Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or technique the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ **The first day of my last menstrual cycle was on _____-_____-_____ Date**

☐ **I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant. By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.**

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Choose Life Wellness Center (CLWC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. CLWC reserves the right to revise its Notice of Privacy Practices. I have the right to request that CLWC restrict how it uses or discloses my PHI to carry out TPO. With this consent, CLWC may call, mail or email me PHI in reference to matters that assist in carrying out TPO, such as appointment reminders, patient statements, and insurance items pertaining to my care. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or my insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, CLWC may decline to provide treatment to me.

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I herby authorize the doctor to examine and treat my conditions he deems appropriate through the use of Chiropractic health care, and I give authority for these procedures to be preformed. It is understood and agreed the amount paid the doctor for radiographs is for examination only and the radiographs will remain the property of the office. The patient also agrees the he/she is responsible for all bills incurred at the office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medically diagnosis.

Patient's Name_____

Signature:_____ Date: _____