LIVEWELL HEALTH AND WELLNESS

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Chiropractic Registration and History

Confidential Information

Date_____

Name_____

M F (Circle One)

Address_____

_____

_____

City, Province _____

Postal Code_____

Home Telephone

_____

Is it okay to leave a message_____

Business Telephone

_____

Is it okay to leave a message_____

Would you like appointment reminders via email? Y N

Email Address:

_____

Occupation_____

Date of Birth (D/M/Y)_____

How did you hear about us?

_____

Prior Chiropractic Care:

Name_____

X-rays taken: YES NO
Date:_____

Medical Doctor:

Name_____

Address_____

_____

Reason for visit:

_____

When did symptoms appear?

_____

Rate the severity of your condition on a scale of 0 (least) and 10 (worst)

_____

_____

How often do you have this pain?

_____

Is it constant or come and go?

_____

PATIENT PAST HISTORY FORM

Do you smoke: YES NO

Do you consume alcohol: YES NO

Do you exercise: YES NO

Indoor exercise Activities_____

Outdoor exercise Activities_____

Have you ever had a diagnosed disease or condition? List. _____

_____

Falls and Accidents_____

_____

Surgery and Operations_____

_____

Surgery recommended but not performed_____

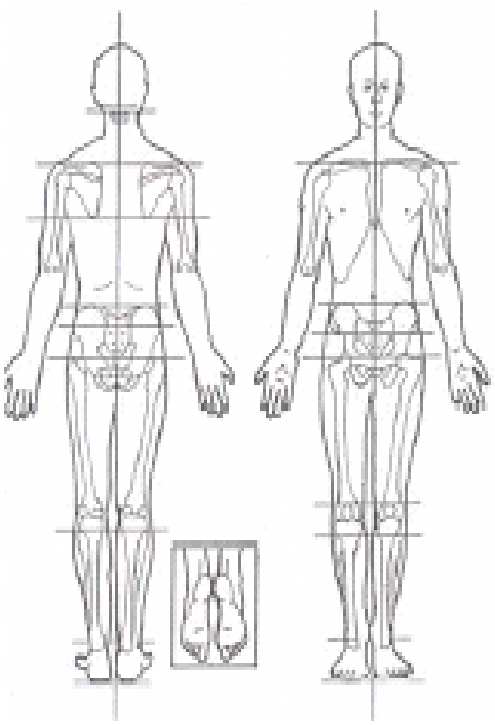
List any supplements you are taking_____

List any medications or drugs you are currently taking_____

_____

_____

Show area of unusual pain/feeling. Mark the areas on this body where you feel the described sensations.



1. Have you ever had this condition before? Yes or No
   If yes, when? _____
2. Is the condition worse in the morning or night? _____
3. Does it affect your sleep? _____
4. Have you tried anything to treat this condition? Yes or No
   If yes, please explain. _____
5. Does it hurt when you cough or sneeze? _____
6. Describe, in your own words, what it feels like. _____
   _____
   _____