Patient Name:_____ Date:_____

Patient Information Sheet

Please print clearly and complete all information

How did you hear about us? ❑ Friend/Family ❑ Internet ❑ Brochure/Advertisement ❑ Other_____
If you were referred by someone please specify (name):_____

Patient name:_____ Birthdate(mm/dd/yyyy):_____ Gender:_____
Address:_____ City:_____ Postal Code:_____
Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( )_____
Email Address:_____ Occupation:_____
Emergency Contact (name):_____ Relationship to Patient:_____
Emergency Contact Phone Number: ( )_____

Have you had previous chiropractic care? ❑ Yes ❑ No If yes, when was your last visit?_____
Who is your Medical Doctor?_____ Phone Number: ( )_____
Who is your Massage Therapist?_____ Other Healthcare Practitioner?_____

Welcome to LiveWell Health and Wellness. We want you to understand and consent to the services we provide to you, the costs involved, and what we do with personal information we obtain from you. If you have any questions regarding this, please ask.

Our expectation of patients for services rendered by LiveWell Health and Wellness:

- We expect all patients to pay for all services when they are provided. If you do not pay for a service at the time it is received, to pay interest on any outstanding balance at the rate of 3% per month and, on default, to pay all costs of recovering debt, including legal and/or agent costs;
- We expect all patients to provide **24 hours' notice when cancelling an appointment**. Your appointment time is reserved exclusively for you and our professional cannot use this time to see other patients if you do not provide 24 hours' notice of cancellation; you agree to pay our standard fee for the missed appointment, as if you had attended.
- The Fee Schedule is: New Patient Examination is $80.00. Subsequent Treatments are $40.00. Extended Treatments are $55.00. Re-Assessments (greater than 3 months) are $65.00.

Print Patient Name:_____

Patient/Guardian Signature:_____ Date:_____

What is your reason for consulting LiveWell Health and Wellness? (Please check one)

❑ I have a specific problem and only require help with this problem
❑ After my problem has been relieved I want to ensure the problem does not return
❑ Spinal check-up and to improve my general health

Reason for appointment/Current Complaint:_____
Previous illness or injuries:_____
Is this condition: ❑Rapid Onset ❑Gradual Onset ❑Auto Related ❑WSIB Claim ❑Other_____

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Patient Name:_____ Date:_____

When/how did this condition begin?_____
Has this problem occurred before? ❑Yes ❑No

Does the pain spread to other areas? ❑Yes ❑No If Yes, where?_____
Is it getting: ❑Better ❑Worse ❑Staying the same

What makes your symptoms *worse*? ❑Sitting ❑Standing ❑Lying down ❑Bending ❑Twisting ❑Lifting ❑Other_____
What makes your symptoms *better*? ❑Rest ❑Ice ❑Heat ❑Massage ❑Medication ❑Other_____

Is your complaint: ❑Constant ❑Intermittent ❑Reoccurring
Have you seen someone else for this condition? ❑Yes ❑No If Yes, what type of treatment?_____
Results of treatment:_____

Medical History
Current Medications:_____
Current Supplements:_____
Any past/current major illnesses:_____
Any allergies:_____
Significant family medical history:_____
Any surgeries or hospitalizations:_____
Any previous imaging?: ❑X-Ray ❑MRI ❑CT Scan ❑Diagnostic Ultrasound ❑Bone Density ❑Other_____
If Yes to imaging, what region/result?_____
Do you smoke? ❑Yes ❑No If Yes, how many packs per day?_____ for_____years
Do you consume alcohol? ❑Yes ❑No If Yes, how many drinks per week?_____
Rate your diet: ❑Poor ❑Fair ❑Moderate ❑Good ❑Excellent
Rate your overall health: ❑Poor ❑Fair ❑Moderate ❑Good ❑Excellent

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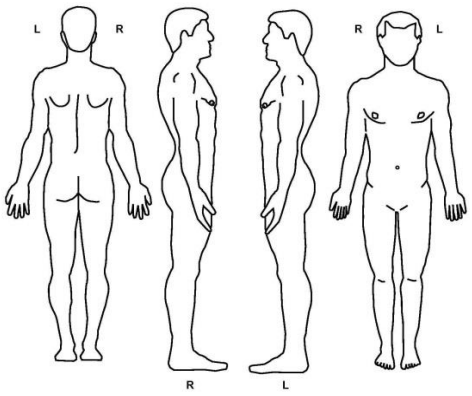
Patient Name:_____ Date:_____

Please place an "X" on the scale indicating the severity of your pain:

(Least) 1 2 3 4 5 6 7 8 9 10 (Worst)

Please complete the following "pain diagram". Using the codes below, indicate on the diagram your area(s) of pain or discomfort:

Dull Ache	(A)
Sharp	(H)
Tingling	(T)
Numbness	(N)
Burning	(B)
Stiffness	(F)
Tight	(G)
Other	(X)



Please check any symptoms that you have had in the past or are presently experiencing.
Circle "C" (Current) and/or "P" (Past)

MUSCULOSKELETAL	GENERAL	CARDIOVASCULAR
C P Low back pain	**C P** Fatigue	**C P** Chest pain
C P Mid back pain	**C P** Allergies	**C P** Short of breath
C P Neck pain	**C P** Loss of sleep	**C P** High blood pressure
C P Arm pain	**C P** Fever	**C P** Irregular heart beat
C P Joint pain/stiffness	**C P** Headaches	**C P** Lung problems
C P Problems walking	**C P** Night pain	**C P** Varicose veins
C P General stiffness		**C P** Ankle swelling
	GENITO-URINARY	**C P** Calf pain/redness
NERVOUS SYSTEM	**C P** Bladder issues	**C P** Stroke/heart attack
C P Nervousness	**C P** Painful urination	
C P Numbness	**C P** Discoloured urine	GASTROINTESTINAL
C P Paralysis		**C P** Decreased appetite
C P Dizziness	EENT	**C P** Excessive thirst
C P Forgetfulness	**C P** Vision problems	**C P** Frequent nausea
C P Confusion/depression	**C P** Sinus problems	**C P** Vomiting
C P Fainting	**C P** Ear aches	**C P** Diarrhea
C P Convulsions/seizures	**C P** Difficulty hearing	**C P** Constipation
C P Tingling	**C P** Frequent colds	**C P** Hemorrhoids
C P Loss of sensation		**C P** Weight loss
C P Stress	MALE/FEMALE	**C P** Abdominal cramps
Rate your stress on a scale of 1-10	**C P** Irregular menstruation	**C P** Gas/bloating
where 10=highest _____	**C P** Menstrual cramps	**C P** Heartburn
	C P Vaginal pain/infection	**C P** Black/bloody stool
	C P Prostate problems	**C P** Colitis
	C P Other	**C P** Crohn's disease

Any other medical conditions not listed:_____

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