IN OFFICE USE ONLY

BP: HT:

WT: HR:

LIVING HARMONY

Name _____ DOB _____

What name do you prefer to be called _____ Age _____ O Female O Male

Marital Status O Single O Married O Widowed O Divorced

Address _____ City _____

State _____ Zip Code _____ Email _____

SS# _____ Cell Phone _____

O Check this box if you would like to OPT OUT of appointment reminder texts and emails
O Check this box if you would like to OPT OUT of emails pertaining to office announcements
Employer _____ Occupation _____

Emergency Contact Name _____ Relation _____

Emergency Contact Phone _____

Who can we thank for referring you to our office? _____

MEDICAL HISTORY

When did your condition begin? _____

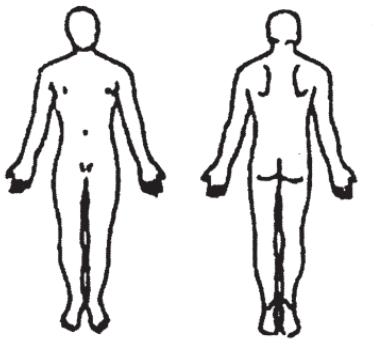
Have you seen other doctors for this condition? _____

Have you had similar symptoms before? O Y O N Date of prior episode _____

List Chief Symptoms in Order of Severity:

1) _____
2) _____
3) _____

Mark Areas of Pain on Figures Below



Please list treatment you have received for this episode/condition:

_____

_____

Have you received chiropractic care before? O YES O NO

Family Physician _____ Date of Last Exam _____

May we forward our findings to your family provider? O YES O NO

Current Medications:

_____

_____

Any Vitamins/Supplements/Herbs:

_____

Allergies (Medicine, Food, Environment):

_____

Please List Major Surgeries and Approximate Dates:

_____

_____

Do you or family have a history of any of the following:

	Self	Family	If yes, please provide any information related to the condition
Cancer			
Diabetes			
Heart Disease			
Stroke			

Check All Symptoms that Apply to You:

O Headache O Tingling/Numbness in arms/hands O Chest Pain

O Loss of Balance O Tingling/Numbness in legs/toes O Fatigue

O Dizziness O Shortness of Breath O Night Sweats

O Fever O Pain unrelieved by rest/Pain at night O Blood in urine

O Urinary Incontinence O Fecal Incontinence O Other _____

HABITS	None	Light	Moderate	Heavy
Alcohol	O	O	O	O
Coffee/Energy Drinks/Soda	O	O	O	O
Tobacco/Vaping	O	O	O	O
Exercise	O	O	O	O
Sleep	O	O	O	O
Water	O	O	O	O

WOMEN

Are you pregnant? O YES O NO Due Date _____ # of children _____

Are you currently on birth control? O YES O NO If yes, list type _____

INSURANCE INFORMATION

HEALTH INSURANCE

I hereby authorize Living Harmony Center to release and/or receive any and all information: 1) information requested by my insurance company or workman's compensation carrier, 2) Information any hospital or physician you may refer me to and/or, 3) information from hospitals or physicians who have previously rendered treatment.

I understand that I am ultimately responsible for payment of any and all charges and if this assignment of claim is rejected, modified, or not paid within a reasonable time after it has been filed, it may be my responsibility to pay any unpaid charges in full. I hereby authorize payment of medical benefits to Living Harmony Center.

Signature of Patient or Guardian _____ Date _____

Primary Insurance _____
Policyholder's Name _____ Policyholder's DOB _____
Relationship to Patient _____

Secondary Insurance _____
Policyholder's Name _____ Policyholder's DOB _____
Relationship to Patient _____

WORKERS COMPENSATION

Is your condition due to an EMPLOYMENT RELATED INJURY? O Y O N Have you reported it? O Y O N

Date of Accident _____ Employer _____
BWC Case Number _____SSN _____

AUTO ACCIDENT

Is your condition related to a recent automobile accident? O Y O N

Auto Insurance Name (if using MEDPAY) _____ Claim # _____
Adjustor Name _____ Phone Number _____
Attorney Name _____ Phone Number _____

In addition to Chiropractic Treatment, we offer the following services and products that may help to improve your condition. If you are interested in additional information, please circle yes to the following

- MASSAGE THERAPY YES NO
  - Hands on therapy to reduce pain and tightness in affected muscle groups
  - Great for LOW BACK and NECK pain
- DRY NEEDLING YES NO
  - Using tiny needles to directly target affected muscles and nerves to reduce pain, inflammation, and tightness while improving blood flow
  - Great for HEADACHES, TENDONITIS, and SORENESS
- COLD LASER YES NO
  - Non-invasive laser therapy to promote quicker healing times in injured areas
  - Great for NERVE PAIN, ACUTE INJURIES, and LOW BACK PAIN
- ESSENTIAL OILS YES NO
  - Work one on one with our wellness advocate to determine which oils would most benefit your situation
- FOOT ORTHOTICS YES NO
  - We offer both Custom Footleveler Orthotics and Powerstep Insoles to provide support from the ground up
  - Great for LOW BACK PAIN, KNEE and HIP PAIN, and PLANTAR FASCIITIS
- TENS/EMS UNITS YES NO
  - Therapy you can take home with you to reduce pain, tightness, and inflammation in the injured areas

CONSENT TO RECEIVE TREATMENT

I hereby authorize the doctors at Living Harmony Center to administer treatment, physical examinations, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case. I do hereby consent to the performance of non-surgical treatment, including but not limited to spinal and extremity manipulation, physical therapy modalities, soft tissue massage, and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke.

I understand there is no certainty that I will achieve benefit from treatment and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures including medication and/or surgery.

Patient's Signature _____ Date _____

CONSENT TO TREAT A MINOR

I (we) being the parent or legal guardian of the minor _____(patient name), age _____, do hereby authorize, request, and direct this clinic, its doctors and staff to perform examinations and treatment that in their judgement, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as the legal parent/guardian to continue with examinations and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

Parent/Guardian Signature _____ Date _____