LIFESOURCE
HEALTH & WELLNESS CENTER

Patient Application for Treatment

Name:_______________________________________ Date:___________________
Address:____
City:________________________________ State:_________ Zip:________________
SS#:_______-_____-______ Age:_______ DOB:_______________ Male / Female
Home #:__________________ Cell #____________________ Work #_______________
Email Address:____

Occupation:______________________ Employer:_______________________________
Employer's Address:____
City:___________________________________ State:_________ Zip:_______________
Insurance Information:____

Marital Status:__________________ Spouse's Name:____________________________
Spouse's Occupation:_______________________ Spouse's DOB:____________________
How Many Children Do You Have?___________ Children's Ages:____________________
Emergency Contact Name:______________________ Phone #:_______________________

How Often Do You Drink Alcoholic Beverages?___________________________________
Do You Smoke? ☐ Yes ☐ No How Much?_______________________________________
Do You Exercise? ☐ Yes ☐ No How Often?____________________________________
Do You Have Any Allergies? (specify)____
Are You Pregnant?______________ Date of Last Menstrual Period?_________________

Have You Ever Received Chiropractic Care? ☐ Yes ☐ No X-Rays Taken? ☐ Yes ☐ No
When Was Your Last Adjustment? _______ Which Office?___________________________
Who May We Thank For Referring You To The Office?______________________________
What Medications Are You Currently Taking?______________________________________
____
What Surgeries Have You Had? ____
____
List Any Recent Accidents or Falls:____

Chief Complaint

What Is Your Primary Complaint? (Why are you here today): ___________________________
____
How Long Have You Been Experiencing This Problem?_____________________________
On A Scale of 1 to 10, How Severe Is It At It's Worst From 0 (no pain) to 10 (disabling pain)
0 1 2 3 4 5 6 7 8 9 10
What Percent of Your Awake Time Do You Experience Your Main Complaint? (Circle)
0 10 20 30 40 50 60 70 80 90 100%
What Makes It Feel Better?____
What Makes It Feel Worse?____
When Do You Notice It Most? (circle) Morning Afternoon Evening
I Have: ☐ Been Hospitalized ☐ Been Seen By Another Chiropractor
☐ Been Seen By Another Doctor ☐ Never Received Treatment For This Problem.

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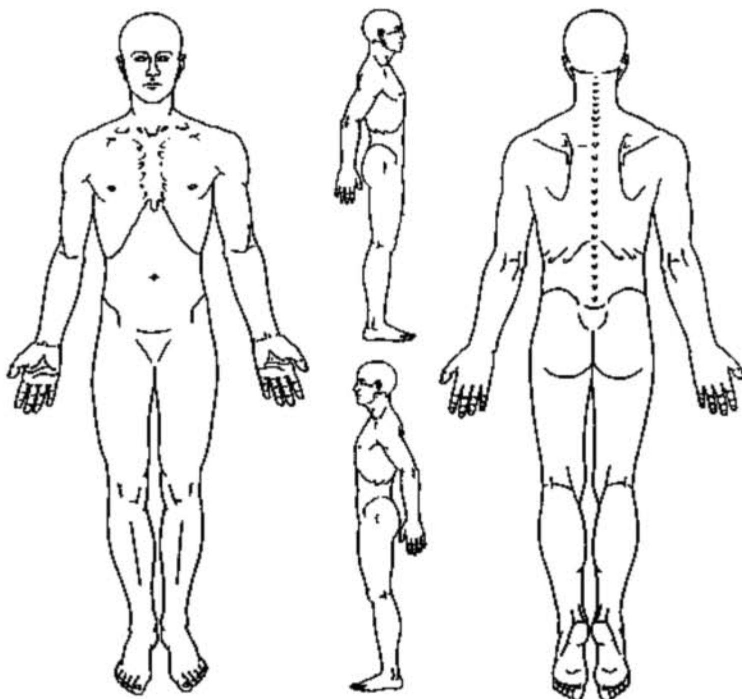
On the diagram below, label ALL areas you are experiencing symptoms using the appropriate letter from the box below.

A=Aching	**C=Cramping**	**R=Throbbing Pain**	**N=Numbness**	**O=Other**
B=Burning	**D=Dull Pain**	**S=Stiffness**	**T=Tingling**	



Additional Complaints

Mark with an "X" Current Symptoms and "O" Past Symptoms

___ Arthritis
___ Diabetes
___ Swollen/Painful Joints
___ Cancer
___ Depressed
___ Allergies/Sinus
___ Trouble Sleeping
___ Headaches
___ Trouble Concentrating
___ Learning Disability
___ Mood Changes
___ Dizziness
___ Neck Pain
___ Numbness/Tingling Hands / Legs / Feet
___ Shoulders Feel Tired
___ TMJ Pain
___ Asthma
___ Loss of Balance
___ Upper/Mid Back Pain

___ Shoulder Pain
___ Ear Infections
___ Low Back Pain
___ Pain with Cough/Sneeze
___ Chest Pain
___ Hip Pain
___ Gall Bladder
___ Stroke
___ Ulcers
___ High/Low Blood Pressure
___ Heartburn
___ Heart Problems
___ Kidney Problems
___ Bed Wetting
___ Diarrhea/Constipation
___ Tremors
___ Colon Trouble
___ Prostate Problems
___ Menstrual Problems

___ PMS
___ Menopausal Problems
___ Foot Trouble
___ Fainting
___ Coughing Blood
___ Pacemaker
___ HIV Positive
___ Tumors
___ Eating Disorder
___ Epilepsy
___ Congenital Disease
___ Alcoholism
___ Drug Addiction
___ Excessive Bleeding
___ Heart Attack
___ Migraines
___ Broken Bones
List:________________
___ ADD/ADHD
___ Thyroid Problems

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation and I am responsible for payment of healthcare services.

Signature: ________________________________ *Date:* ______________________

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Health History of Family Members

The reason for this form is to assist the doctor by providing past health history information for their review

Condition	Self	Mother	Spouse	Brothers	Sisters	Children
Arthritis						
Asthma						
Back Pain						
Cancer						
Constipation						
Diabetes						
Difficulty Sleeping						
Disc Problems						
Ear Problems						
Emphysema						
Epilepsy/Seizures						
Fatigue						
Headaches						
Heart Trouble						
High Blood Pressure						
Kidney Trouble						
Migraine						
Nervousness						
Neck Pain						
Numbness						
Pinched Nerve						
Scoliosis						
Sinuses & Allergies						
Stomach Trouble						

LIFESOURCE LLC
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TERMS OF ACCEPTANCE AND CONSENT FOR CARE

We will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The primary focus of chiropractic care is the detection and correction of vertebral subluxation. This is a misalignment of one or multiple spinal bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms. Through specific chiropractic adjustments, we reduce and/or correct subluxations. The risks of physical medicine, chiropractic care are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations. I understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I hereby give consent to LifeSource Health & Wellness, LLC to evaluate me to determine my condition and treat me for such conditions. I also understand that I may discontinue treatment if I so choose.

FOR MINORS; I,__________________________ being the parent or legal guardian of __________________________(print minor's name) fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.
Signature ______________________________Date_______________

PREGNANCY RELEASE: This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permissions to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual period ______________

I,(print name); ______________________________ have read and fully understand the above statements.

Signature; ____ Date; _______________

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