LIVING WELL MEDICAL, P.C.

632 Broadway Suite 303 New York, NY 10012
Telephone: (212) 645-8151

CONFIDENTIAL PATIENT CASE HISTORY

PATIENT INFORMATION *PLEASE PRINT NEATLY*

First Name: _____ Last Name: _____

Social Security #: ____-_____-_____ Date of Birth: ___ / ___ / _____ Email:_____

Address: _____Apt#_____City: _____State:____ Zip Code: _ _ _ _ _

Home Phone: _____-_____ Work Phone: _____-_____ Cell: _____ - _____

Marital Status: M S W D LP Occupation: _____ Who referred you to our office: _____

Emergency contact: _____ Phone: _____-_____ Relation:_____

PRIMARY INSURED INFORMATION *PLEASE FILL OUT IF **YOU ARE NOT** THE PRIMARY INSURED*

Name: _____ Relation to Insured: _____

Address: _____Apt#_____City: _____State:____ Zip Code: _ _ _ _ _

Date of Birth: ___ / ___ / _____

HEALTH INFORMATION

What is your major complaint?

_____

_____

How long have you had this condition? _____
Have you had this or similar conditions in the past? Yes □ No □ If Yes; When? _____

What activities aggravate this condition: (Please check all that apply)
□ Excessive Sitting □ Excessive Standing □ Stress □ Walking □ Running □ Exercise □ Bike Riding □ Daily Activities
□ Bending □ House Cleaning □ Other (Please Explain) _____

Does this condition interfere with your? (Please check all that apply)
□ Work □ Sleep □ Daily Routine □ Other (Please Explain) _____

How long has it been since you really felt good?
□ Yesterday □ One week ago □ one month ago □ Don't remember

Please list all doctors you have seen for this condition. (If none check box) □

_____ _____ _____

List all surgical operations and years they were performed. (If none check box) □

_____

_____

Please list all medications. (If none check box) □

_____

_____

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Age of Mattress: □ Less than 6 months □ More than 1 year □ More than 5 years □ don't know

When was your last physical examination: _____

HAVE YOU EVER SUFFERED FROM THE FOLLOWING?

1. Dizziness □ Yes □ No
2. Backaches □ Yes □ No
3. Heart Trouble □ Yes □ No
4. Diabetes □ Yes □ No
5. Headaches □ Yes □ No
6. Asthma □ Yes □ No
7. Arthritis □ Yes □ No
8. Neuritis □ Yes □ No
9. Digestive Disorders □ Yes □ No
10. Nervousness □ Yes □ No
11. Sinus Trouble □ Yes □ No
12. Automobile Accident □ Yes □ No When? _____
13. Work related accident □ Yes □ No When? _____

Family Health Information – (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

Name of Family Member	Relation	Past and Present Health Problems

INSURANCE INFORMATION:

Do you have health insurance? □ Yes □ No If yes, **please present your insurance card to the reception area** in order for them to have a copy in our records. Thank you.

Does Medicare cover you? □ Yes □ No If yes, please provide the following information.

Medicare Card #: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and 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 me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____