Lawson Chiropractic
Wellness Center

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Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name_____ Date_____ S/S_____-_____-_____
First MI Last

Address_____ City_____ State_____ Zip_____

Sex: ☐ Female ☐ Male

Birth date_____ Home Phone #_____ Work Phone #_____

Do you prefer to recieve calls at : ☐ Home ☐ Work ☐ Either

Are you: ☐ Minor ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Your employer_____Occupation_____

Business Address_____ City_____ State_____ Zip_____

Spouse's or Parents Name_____ Work phone #_____

Referred by ☐ Friend/Relative ☐ Newspaper ☐ Yellow pages ☐ Sign ☐ Other

Whom may we thank for referring you to us?_____

Person to contact in case of emergency_____ Phone #_____

Hobbies_____

Payment Information

I understand that payment is expected at the time of service. I choose to pay by:

☐ Cash ☐ Check ☐ Credit Card ☐ Insurance

Name of person responsible for this acount?_____

Relationship to Patient_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Do you have health insurance to file? ☐ Yes ☐ No Is this insurance through your work? ☐ Yes ☐ No

Insurance Company_____ Phone # _____ Group #_____

Do you have a secondary insurance through your spouse's employer? ☐ Yes ☐No

Name of Primary Care Physician_____ Phone #_____

Chiropractic History

Have you ever been adjusted by a Chiropractor before? ☐ Yes ☐ No

Reason for those visits?_____

Doctor's Name _____ City_____

Approximate date of last visit_____ Number of visits at this chiropractor?_____

Are you aware that...

...Doctors of Chiropractic work with the nervous system? ☐ Yes ☐ No

...the nervous system controls all bodily functions and systems? ☐ Yes ☐ No

...if Chiropractic starts at birth, you can achieve a higher level of health throughout your life? ☐ Yes ☐ No

Reason for this Visit

Please list the primary complaint for which you are seeking care_____

_____

When did the problem begin?_____Cause of problem?_____

Type of Pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Stiff ☐ Burning ☐ Tingling ☐ Numb

Frequency of pain ☐ Constant ☐ Intermittent ☐ Times /week_____ ☐ Times/month_____

What makes the problem better?_____

Have you tried any self-treatment such as ☐ Ice ☐ Heat ☐ Exercise ☐ Rest ☐ Medication

What makes the problem worse?_____

Have you ever had a similar problem in the past? ☐Yes ☐ No

Explain_____

Have you seen any other doctors for this condition? ☐ Yes ☐ No Who?_____

If yes, what was the diagnosis and treatment? _____

_____

Are you currently on any medications? ☐ Yes ☐ No

If yes, please list all (include name, dose and reason)_____

_____

_____

_____

Have you missed work as a result of this problem? ☐ Yes ☐No How much?_____

Has this condition interfered with any of the following ☐ Sleep ☐ Appetite ☐ Social Life ☐ Energy Level ☐ Job

☐ Family ☐ Bowel Movements ☐ Urination ☐ Appetite ☐ Menstral Cycle ☐ Sex Life ☐Other_____

Past History

List known health conditions (high blood pressure, heart condtions, diabetes, etc.)_____

_____

_____

Previous Surgeries and the dates which they occured_____

_____

Are you pregnant? ☐ Yes ☐ No Due Date_____

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? (Sitting, standing, heavy labor, computer work, etc.)_____

_____

Do you smoke? ☐ Yes ☐ No How much per day?_____

Have you ever been treated for alcohol or substance abuse? ☐ Yes ☐ No

Authorization for Care

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services will become immediately due and payable. It is understood and agreed that the payments to the Doctor for x-rays is for the examination of x-rays only. The x-ray negatives will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient of this office. If a copy of these xrays is requested by the patient, he or she will be responsible for a reproduction fee.

X_____

Signature of Patient (or parent if a minor) **Date**