



Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Todays Date \_\_\_\_\_

Gender M F Parents Name \_\_\_\_\_ Parents Cell # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

How did you find Live Well \_\_\_ online \_\_\_ location \_\_\_ referred by (name): \_\_\_\_\_

Main reason for consulting Live Well \_\_\_\_\_

Health condition #1 \_\_\_\_\_

When & how did the problem start \_\_\_\_\_ Severity 0 1 2 3 4 5 6 7 8 9 10

Any other details you would like us to know \_\_\_\_\_

Any other concerns with these areas? \_\_\_ shoulder \_\_\_ elbow \_\_\_ wrist \_\_\_ knee \_\_\_ foot/ankle \_\_\_ jaw

Have you been to a chiropractor before? Y N \_\_\_\_\_

Does the reason for your visit today affect your activities of daily living? \_\_\_\_\_

If so, which? \_\_\_ Eating \_\_\_ School \_\_\_ Exercise \_\_\_ Sleep \_\_\_ Walking \_\_\_ Sitting \_\_\_ Standing

Do you often carry a heavy backpack/books? Yes No \_\_\_\_\_

Poor posture leads to poor health and often indicates a spinal problem.

Rate your posture - Poor 1 2 3 4 5 Excellent

Rate your stress level over the last 90 days. Low 1 2 3 4 5 High \_\_\_\_\_

Have you ever been screened for Scoliosis? Yes No If yes, when? \_\_\_\_\_

Do you take part in physical activities/sports? Yes No

If so, which ones and how often per week? \_\_\_\_\_

Long periods of time using technology (phones, computers, video games)? Yes No

How long per day? \_\_\_\_\_ Per week? \_\_\_\_\_

Experience changes associated with puberty? Yes No \_\_\_\_\_

First menstruation: \_\_\_\_\_ Last menstruation: \_\_\_\_\_

Have you had a recent growth spurt? Yes No \_\_\_\_\_

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Dizziness/fainting       | <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Fever              | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Difficulty breathing     | <input type="checkbox"/> Depression              | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Digestive issues     |
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Loss of balance         | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Numbness in fingers/toes | <input type="checkbox"/> Problems urinating      | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Circulatory problems |
| <input type="checkbox"/> Sleeping problems        | <input type="checkbox"/> Constipation/diarrhea   | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Birth control pills  |
| <input type="checkbox"/> Heartburn/reflux         | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Allergies          | <input type="checkbox"/> Sinus problems       |
| <input type="checkbox"/> Menstrual irregularity   | <input type="checkbox"/> Poor immune function    | <input type="checkbox"/> ADHD/ADD           | <input type="checkbox"/> Broken bones         |
| <input type="checkbox"/> Ringing in the ears      | <input type="checkbox"/> Thyroid issues          | <input type="checkbox"/> Gallbladder issues |   |
| <input type="checkbox"/> Nausea                   | <input type="checkbox"/> High/low blood pressure |   |   |

List any surgeries \_\_\_\_\_

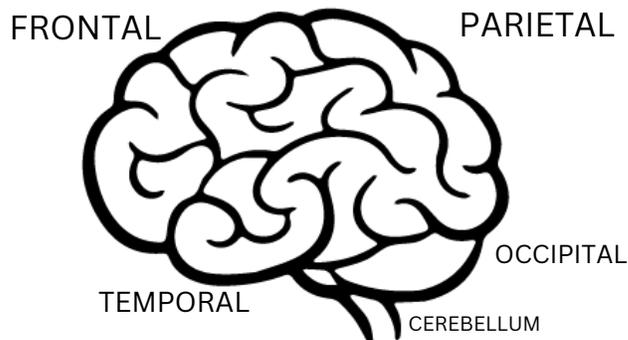
Medications currently taking \_\_\_\_\_

## Brain based common complaints

please mark all that apply

### Frontal Lobe

- learning challenges
- depression
- mood swings
- anxiety
- concentration
- speech difficulties
- overall weakness
- bed wetting/urgency
- slow reaction time
- slowness initiating movement



### Temporal Lobe

- memory loss
- hearing loss
- tinnitus (ringing in the ear)
- difficulty thinking of words
- vertigo
- tourette's
- problems with taste/smell
- decreased sex drive
- difficulty with facial recognition
- speech comprehension issues

### Parietal Lobe

- confusion between L & R
- disorientation
- navigation difficulties
- clumsiness
- missing spots while shaving
- difficulty following stories
- injuring one side more than the other

### Occipital Lobe

- visual floaters
- color blindness
- decreased brightness
- visual auras

### Cerebellum

- tripping often
- poor coordination
- breathing problems
- learning challenges
- motion sickness
- balance issues

## Neurologic problems start at an early age.

Please check any of these that you can remember being present.

### Rooting

- speech issues
- chewing/biting lips
- involuntary tongue or mouth movements
- oral sensitivities
- difficulty with feeding

### ATNR

- poor handwriting
- difficulty reading & tracking/ missing words when reading
- poor hand-eye coordination

### Babinski

- delays in walking
- balance issues
- clumsy - tripping/falling
- walking on tip toes

### Palmer

- poor fine motor skills
- poor/messy handwriting
- poor pencil grip
- poor eye/hand coordination

### Spinal Galant

- inability to sit still or remain silent
- poor concentration
- bed wetting
- needing to have contact with someone while sleeping

### Startle

- sensitive to loud noise or light
- mood swings
- aggressive outbursts
- feeling anxious
- difficulty with change

Why are we asking about parts of your brain at a chiropractic office? Your brain & nervous system are the master coordinators of the function of the body. If there are imbalances in the brain it can lead to many health challenges.

## Live Well Chiropractic

1330 SW 160th Ave

Sunrise, FL 33326

954-384-3275

**NOTICE OF PRIVACY PRACTICES:** The following are policies of Live Well Chiropractic and will be implemented unless patients notify Live Well Chiropractic in writing that they do not wish to participate:

### **OPEN ADJUSTING ENVIRONMENT:**

It is the practice of Live Well Chiropractic to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being in the same adjusting area at the same time. Patients may be within sight of one another and some ongoing routine details of care may be discussed within earshot of other patients and staff. The environment is used for ongoing care and is NOT the environment used for taking patient histories or performing examinations. These procedures are completed in a private, confidential setting. If there is ever a time that you would like to discuss something in private with one of the doctors just ask for a private setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related to an "open adjusting" environment are incidental matters. In the event, you or someone else would not agree with us, we are providing this disclosure.

- It is our desire for our staff to use your name, address, email address and/or telephone number for the purpose of contacting you to advise you about health-related meetings, workshops, and important office information such as office hour changes and cancellations.
- It is our desire for our staff to use your name and/or signature on our sign-in sheets in order to verify your office visit.
- As a courtesy to our patients, if you miss an appointment, it is our policy to call your home to reschedule your appointment time. If you are not home, we will leave a message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment.

The use of this information is intended to make your experience with our office more efficient, productive, and to further enhance your access to quality chiropractic care. If you choose to not authorize the use of this information, your decision will have no adverse effect on your care from Live Well Chiropractic or on your relationship with our staff.

Live Well Chiropractic reserves the right to change this notice and to make the revised Privacy Notice effective for all your protected health information that it contains.

Live Well Chiropractic Privacy Officer is Dr. John Moore. You may contact him at 954.384.3275.

### **ACKNOWLEDGMENT:**

I acknowledge that I have been offered to review a copy of the Live Well Chiropractic Notice of Privacy Practices.

\_\_\_\_\_  
Name of Individual (please print)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Date

If Patient is a Minor, \_\_\_\_\_

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

Live Well Chiropractic  
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## Terms of Acceptance

Welcome to our office! We are excited that you have taken the first step to enjoying a healthier life through safe and effective chiropractic care. We hope to teach and inspire our patients to achieve higher standards of health and wellness. Before we begin there are a few things to review.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

**Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom.** It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

**Adjustment:** the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is specific adjustments of the spine.

**Health:** a state of optimal physical, mental, and social well-being, not merely the absence of disease.

**Vertebral Subluxation:** a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specifically adjusting to correct vertebral subluxations.**

I, \_\_\_\_\_ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

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Signature

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Date



## CONSENT TO TREATMENT OF MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of \_\_\_\_\_, a minor, do hereby authorize

(Name of Minor)

Live Well Chiropractic as agent(s) for the undersigned

(Name of Agent)

to consent to any x-ray, examination, and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization shall remain effective until \_\_\_\_\_, 20\_\_\_\_\_,  
(Date of child's 18th birthday) (Month and Day) (Year)

unless sooner revoked in writing delivered to the agent(s) noted above.

Date \_\_\_\_\_

Print Name: \_\_\_\_\_  
(Parent/legal guardian/person having legal custody)

Relationship to Patient: \_\_\_\_\_

Signature \_\_\_\_\_  
(Parent/legal guardian/person having legal custody)