Life Long Wellness

Confidential Patient Information

Todays Date: _____

General Information

Name_____ Sex_____ Age_____

Address_____ City_____ State_____ Zip_____

Married Single Other Date of Birth _____

Phones: Home _____ Cell _____ Email _____

Occupation _____ Employer _____

How did you hear of our office? _____

Have you ever been through a course of physical therapy? **Y** **N** For what? _____

How often do you exercise? **Never** **Occasionally** **Sometimes** **Regularly**

How confident are you in your body's ability to heal itself?

Not 1 2 3 4 5 6 7 8 9 **Fully**

Focus of Care

What are your reasons for seeking care at our office?_____

What was the initial cause?_____

When did it begin?_____ Since onset, has it gotten better or worse?_____

What makes it feel better?_____

What makes it feel worse?_____

Please check any activities that have been affected:

- ☐ Work
- ☐ Sitting
- ☐ Stretching
- ☐ Relationships
- ☐ Sleep
- ☐ Standing
- ☐ Social Life
- ☐ Exercise
- ☐ Walking
- ☐ Bending
- ☐ Recreation
- ☐ Emotions
- ☐ Other_____

Which are you interested in?

- ☐ Pain Relief
- ☐ Postural Correction
- ☐ Stress Relief
- ☐ Athletic Performance
- ☐ Wellness Care
- ☐ Other _____

How committed are you to correcting this problem? (0 - Not at all, 10 - Completely)

0 1 2 3 4 5 6 7 8 9 10

Please list any medical events, illnesses or diseases for which you have been treated_____

_____

_____

_____

Please list any family history of medical conditions, illnesses or diseases_____

_____

_____

Please list any condition(s) that you take medication for_____

_____

_____

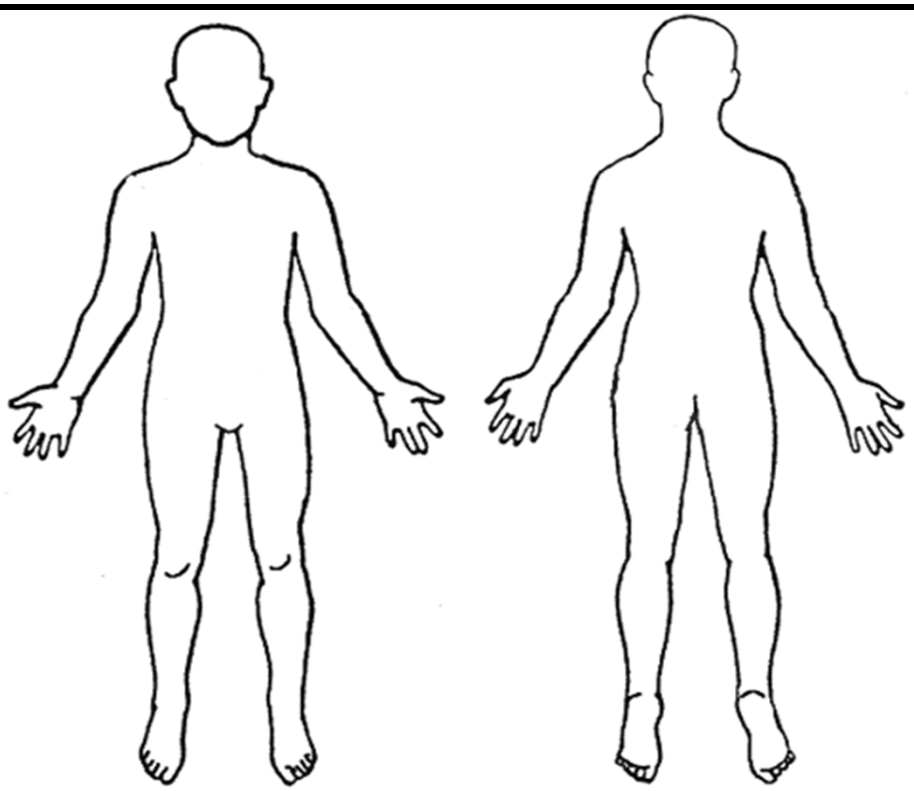
How much water do you drink on an average day? _____

Please list supplements your are taking_____

_____

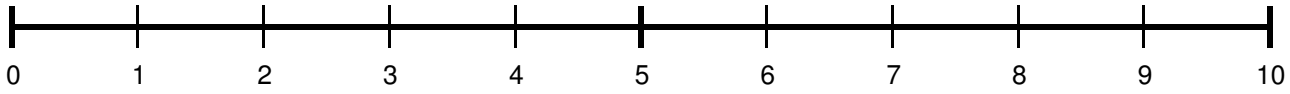
1) Draw your symptoms

2) Draw your face

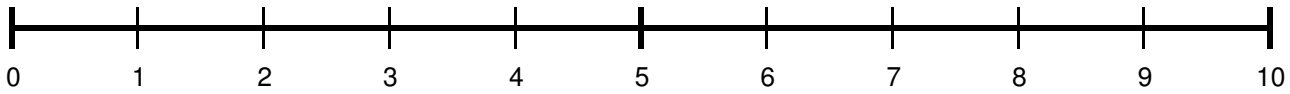


front ***back***

How bad is your complaint on average? (0 - No Pain, 10 - Worst Imaginable)



How bad is your complaint at its worst? (0 - No Pain, 10 - Worst Imaginable)



By signing below, I certify that the information above is true and correct and I agree to notify the doctor/staff of any changes as they occur. I authorize Life Long Wellness to obtain verification of my insurance coverage and understand that such verification is not a guarantee of payment. I understand and agree that insurance policies are an arrangement between the insurance carrier and myself. I authorize the release of any medical information necessary to process insurance claims. I also request and authorize payment of benefits either to myself or to Life Long Wellness or Jason D Atkinson, DCif they accept assignment. I hereby authorize Life Long Wellness, its doctors and staff to perform examination and to render treatment as they so deem necessary. I understand that I am seeking holistic and not allopathic care and that information obtained during my examination is of a holistc nature and that a allopathic/medical diagnosis will not be given. I understand that my personal and medical information are private and protected by HIPAA law and that any release of such information will require my consent and signature.

Printed Name_____

Signature of Patient (or Guardian)_____