WALSEMANN-LANZARA CHIROPRACTIC LIFE CENTER P.A

39 Myrtle Street, Claremont, NH 03743

Name: _____ S.S.#_____ Date:_____
Mailing Address: _____ City:_____ State:____ Zip:_____

Phone:( )_____ Date of Birth:_____ Age:_____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W
Occupation:_____ Employer:_____ Phone(work)_____
Spouse's Name:_____ No. of Children_____ Referred By:_____

Have you seen a Chiropractor previously? Y ☐ N ☐ Reason for consulting our office?_____

Do you have INSURANCE? Y☐ N ☐ ** **PLEASE GIVE YOUR CARD TO A STAFF MEMBER TO BE COPIED** **

Is this an injury due to Workman's compensation? YES ☐ NO ☐ Have you reported this injury to your employer? YES ☐ NO ☐

Do you plan on turning this in as a Workman's Compensation Claim? Y ☐ N ☐ Is this injury due to a Motor Vehicle Accident? Y ☐ N ☐

YOUR HEALTH PROFILE

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

CHILDHOOD YEARS	YES	NO	UNSURE		Y	N	UN
Did you have any childhood illnesses?	☐	☐	☐	Did you have any serious falls as a child?	☐	☐	☐
Did you take / use any drugs?	☐	☐	☐	Did you play youth sports?	☐	☐	☐
Did you have any surgery?	☐	☐	☐	Were you vaccinated?	☐	☐	☐
Have you fallen / jumped from a height over three feet?	☐	☐	☐	Were you involved in any car Accidents as a child?	☐	☐	☐
Did you suffer any other traumas (Physical or emotional)	☐	☐	☐	As a child were you under regular chiropractic care?	☐	☐	☐
Was there prolonged use of medicine Such as antibiotics and/or inhaler?	☐	☐	☐				

Comments:_____

ADULT (18 TO PRESENT)	YES	NO		YES	NO
Do / did you smoke?	☐	☐	Do / did you play adult sports?	☐	☐
Do / did you drink alcohol?	☐	☐	Do / did you participate in extreme sports?	☐	☐
Have you been in any accidents?	☐	☐	On a scale of 1-10 describe your stress level: (1= None/10= Extreme)		
Have you had any surgery?	☐	☐	Occupational_____ Personal_____		

On a scale of Poor, Good, Excellent describe your: Diet_____ Exercise_____ Sleep_____ General Health_____

Women: Are you currently pregnant? ☐ **YES** ☐ **NO** What is your expected due date?_____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you have no symptoms or complaints, and are here for wellness services, please mark (x) here___ **"Wish to have Chiropractic wellness services"** and skip to **"Family Health Profile."** Others need to briefly describe the chief area of complaint, including the effect is has had on your life._____

_____

If you are experiencing pain, is it... ☐ Sharp ☐ Dull ☐ Comes and goes ☐Travels ☐ Constant

Since the problem started, it is... ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse:_____

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctor's seen for this problem (please list)

Chiropractor_____ Medical Doctor_____ Physical Therapist_____

Other_____

Please Mark (X) all symptoms you have ever had, even if they are not related to your current problem(s).

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck Pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold sweats	☐ Lights bother eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual pain	☐ Menstrual irregularity	☐ Ulcers

FAMILY HEALTH PROFILE:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children_____

Spouse_____

Mother_____

Father_____

Brothers_____

Sisters_____

Others_____

Have you ever:

Bought bottled water:	☐ **YES**	☐ **NO**
Belonged to a health club:	☐ **YES**	☐ **NO**
Consumed vitamins or supplements:	☐ **YES**	☐ **NO**

List any medications you are taking _____

AUTHORIZATION AND ASSIGNMENT

It is my understanding that if I become a patient in this office, I agree to the following:

- Payment is required at the time of service unless other financial arrangements are made in advance.
- If financial arrangements are made, and Walsemann-Lanzara Chiropractic Life Center allows me to charge services rendered to me, I authorize the release of any information concerning my condition to any insurance company, attorney, or adjuster in order to receive reimbursement on any charges incurred by me as a result of services rendered by WLCLC professionally.
- I also authorize direct payment to WLCLC of any sum that I owe now or in the future from any insurance company that is obligated to reimburse me for charges incurred at WLCLC.
- I realize my **insurance does not guarantee payment** for any services rendered at WLCLC and agree to pay all unpaid fees should my insurance policy deny payment.
- The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Signature Date