Welcome to Lowrey Chiropractic & Integrated Wellness

4909 Golden Foothill Parkway, El Dorado Hills
(916) 941-7508

In order to provide you with the best possible care, please complete this form in its entirety (print clearly). All information is strictly confidential.

Date:_____ E-Mail: _____

Patient Name: (First) _____ (Middle)_____ (Last) _____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Mobile Phone #:_____ Secondary Phone #:_____ Gender: ☐ Male ☐ Female

Date of Birth:_____ Age:_____ Social Security #:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Spouse's Name: _____ Is your spouse a patient in our office? ☐ Yes ☐ No

Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Other Occupation/Job Title: _____

Employer/School:_____ Employer Phone:_____

Emergency Contact Name & Relationship: _____ Emergency Phone #:_____

How Did You Hear About Us? ☐ Insurance ☐Google Search ☐ Internet ☐ Yelp ☐ Friend/Family ☐ Doctor/Professional ☐ Other _____
Whom may we thank for referring you to us? _____

MEDICAL INSURANCE INFORMATION

Insurance Company:_____ Type of Health Plan: ☐ PPO ☐ HMO ☐ Medicare ☐ Other

Subscriber ID #:_____ Group #:_____ Insurance Co. Phone:_____

If Other Than the Patient, Please Tell Us About the Insurance Policy Holder

Policy Holder's Name:_____ Policy Holder's Date of Birth:_____ Phone: _____

Relationship to Patient:_____ Policy Holder's Employer: _____

REASON FOR THIS VISIT (PRIMARY COMPLAINT)

Briefly Describe Your Symptoms (Primary Complaint): _____

When did it start? _____ Is it? ❑ Work Related ❑Auto Accident ❑N/A

How did your symptoms start? _____

Rate the severity of your pain: **Mild Discomfort 1 2 3 4 5 6 7 8 9 10 Intense Pain**

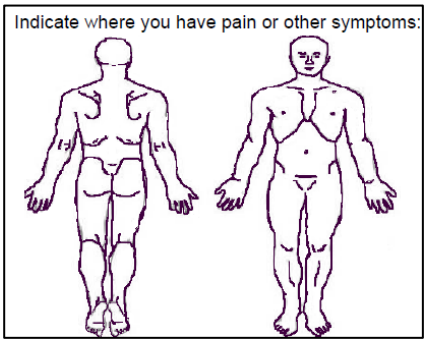
Type of Pain: ❑Sharp ❑Burning ❑Numbness ❑Stiffness ❑Dull ❑Tingling ❑Swelling ❑Other

Does your pain travel? ❑ Yes ❑ No If Yes, from where to where? _____

How ***often*** are your symptoms present? ❑ 0 - 25% ❑ 26-50% ❑ 51-75% ❑ 76-100%

Have you had similar conditions in the past? ❑Yes ❑ No If Yes, when? _____

Is pain interfering with: ❑Work ❑Sleep ❑ Daily Routine ❑Other _____



In the past week, how much has pain interfered with your daily activities including work, sleep, social activities?
No Interference 1 2 3 4 5 6 7 8 9 10 Unable To Carry On Any Activities

Which activities are difficult to perform? ❑Sitting ❑Standing ❑Walking ❑Bending ❑ Lying Down ❑ Other:_____

Is pain getting: ❑Worse ❑Better ❑Same ❑Comes & Goes Is the pain worse in: ❑AM ❑PM ❑Constant

What makes the pain better? _____ What makes the pain worse? _____

In general, would you say your overall health right now is: ❑Excellent ❑Very Good ❑Good ❑Fair ❑Poor

What are your **Primary Goals / Expectations** for this visit? ❑Pain Relief ❑Wellness ❑Evaluation ❑Other

Do you have any other complaints? If so, briefly explain: _____

PAST TREATMENT

Have you ever been treated by a **Chiropractor**? ❑Yes ❑ No If Yes, provide more details below.
Have you been treated by any **Other Health Professionals** for this condition? ❑Yes ❑ No If yes, provide more details below.

Date	**Briefly Explain Details (Who, How Long, and Did it Help?)** *(Use Back Side of Paper If Needed)*

HEALTH HISTORY

List any and all serious injuries, auto accidents, traumas, falls, broken bones, dislocations.

Date	**Explain Serious injuries** *(Use Back Side of Paper If Needed)*

List any surgeries and/or hospitalizations.

Date	**Explain Surgeries and/or Hospitalizations** *(Use Back Side of Paper If Needed)*

Have you had **Spinal X-Rays, MRI, CT-Scan** for your current condition? ❑Yes ❑ No If Yes, Date(s) Taken: _____
What Areas? _____ Reports/Findings: _____

List all drug or medication **allergies:** _____

List all **medications** you are taking and why: *(use back side of paper if needed)*

Medication	**Frequency**	**Reason**		**Medication**	**Frequency**	**Reason**

DAILY HABITS

Do you **Exercise** regularly? ❑ Sedentary (No exercise) ❑Mild/Moderate ❑Heavy (4x/week or more) Daily Work Habits Include? _____

What **Nutritional Supplements/Vitamins** do you currently take? _____

(Woman) Are you Pregnant? ❑Yes ❑ No # Weeks_____ Nursing? ❑Yes ❑ No Taking Birth Control Pills? ❑Yes ❑ No

Do you Smoke/Vape? ❑Yes ❑ No If yes, explain type and frequency: _____

Do you use Recreational Drugs? ❑Yes ❑ No If yes, explain type and frequency: _____

How much **Alcohol** do you consume per week? _____ Caffeinated Beverages per Day: _____

PAST MEDICAL HISTORY

Check all that apply to you including current and past conditions. ❑ No medical history to report.

❑ Heart Attack (date)_____	❑ Diabetes	❑ High Cholesterol	❑ Nervousness	❑ AIDS/HIV
❑ Stroke (date)_____	❑ Cancer (explain) _____	❑ High Blood Pressure	❑ Irritable	❑ Hepatitis
❑ Heart Disease	_____	❑ Lower Back Problems	❑ Depressed	❑ Psychiatric Problems
❑ Heart Defect	❑ Headaches/Migraines	❑ Prostate Problems	❑ Fatigue	❑ Chicken Pox
❑ Shortness of Breath	❑ Arthritis	❑ Menstrual Problems	❑ Loss of Sleep	❑ Measles
❑ Chest Pain	❑ Rheumatoid Arthritis	❑ Urinary Problems	❑ Weight Loss	❑ Shingles
❑ Pacemaker	❑ Osteoporosis	❑ Stomach Pain	❑ Weight Gain	❑ Pneumonia
❑ Fainting	❑ Artificial Bones/Joints	❑ Appendicitis	❑ Loss of Balance	❑ Multiple Sclerosis
❑ Epilepsy/Seizures	❑ Implants	❑ Ulcer/Colitis	❑ Swollen Joints	❑ Rheumatic Fever
❑ Dizziness/Fainting	❑ Anemia	❑ Gout	❑ Alcohol/Drug Dependence	❑ Other (specify)
❑ Ringing in Ears	❑ Difficulty Breathing	❑ Kidney Problems	❑ Fibromyalgia	_____
❑ Severe Earaches	❑ Emphysema/Glaucoma	❑ Tuberculosis		

FAMILY MEDICAL HISTORY

List any Medical Conditions or Disease that has been in your **Immediate Family** Including Cancer, Heart Problems, Stroke, Diabetes, Rheumatoid Arthritis, High Blood Pressure. ❑ No History to Report

	Age / Sex	Significant Health Problem			Age / Sex	Significant Health Problem
Father				**Children**		
Mother						
Sibling						
Sibling						

To the best of my knowledge, the above information is complete and accurate. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have **Insurance coverage with** _____ and assign directly to **Lowrey Chiropractic** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to accept total responsibility and agree to pay at the time the services are rendered. I authorize the use of my signature on all insurance submissions, including electronic submissions.

We often do not know exactly what your insurance company will cover until payment is received. We usually accept insurance payment after any deductible, co-payment or co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

I authorize the release of any medical information necessary to process my insurance claims. I understand that Lowrey Chiropractic may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have been presented with a copy of the **Notice of Privacy Practices**, detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative — Date

_____ _____

Please Print Name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient