

New Patient Health History

Welcome to TLC Holistic Wellness
31580 Schoolcraft Road, Livonia, MI 48150

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The purpose of this office is to provide alternative holistic wellness care to help people reduce their stress so that they can achieve optimal health and wellness for themselves and their family. We provide gentle, non-force chiropractic care, nutrition/diet and homeopathic counseling, detoxification, allergy elimination and natural hormone balancing. Your experience with this office will include improved health and healing of your body, as well as learning the truth about optimal health and wellness.

New Patient Health Information

Please complete all questions and bring this with you on your first visit.

Today's Date: _____

Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Birth Date: _____

Age: _____ Social Security #: _____

Marital Status: M W D S Number of Children: _____

Children's Names & Ages: _____

Your E-Mail Address: _____

(For the purpose of providing you with our Health Newsletter)

Your Employer: _____

Occupation: _____

Spouse's Name: _____

Spouse's Employer: _____

Emergency Contact: _____

Cell Phone: _____ Home Phone: _____

Your Favorite Hobbies: _____

Who may we thank for referring you? _____

New Patient Health History

When did you last see a Chiropractor? _____

Name of Medical or Chiropractor _____

Other Doctors you've seen recently: _____

OTC/Prescription Medicines you take: _____

Vitamins you take: _____

Reason for Your Visit: _____

Are you here because of a recent auto or work injury? Yes No

Date of Accident: _____

Ever diagnosed with cancer? Yes No What kind? _____

Injuries or Surgeries that you've had that have created scar tissue:
(circle all that apply; write in others)

Hysterectomy Episiotomy C-Section Appendectomy Tonsils
Gall Bladder Cataracts Knee Hip Back Feet Hands Other

A. The vast majority of our patients have experienced dozens of impacts that could cause physical stress and health problems. Help us discover yours.

1. How many total auto accidents/fender benders have you been involved in? (please circle)

5+ 3-4 1-2 0 Motorcycle accidents? Yes No

Four Wheeling? Yes No Bicycling? Yes No

2. Which of the following sports have you been involved in?
(please circle)

Football	Soccer	Field Hockey	Gymnastics	Basketball
Horseback Riding		Martial Arts	Rollerblading	Ice Hockey
Skating	Skiing	Sledding	Snowmobiling	Ski Diving
Dance	Ballet	Softball	Volleyball	Water Skiing

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Other: _____

3. Have you ever . . . (please check)

- fallen down the stairs
- slipped on ice or snow
- had a stress or strain while working
- had a sports injury
- had a work or personal injury

4. Do you . . . (please check)

- sit more than four hours per day
- drive more than two hours per day

5. Are you a . . . (please check)

- computer operator
- assembly line worker
- truck driver
- single or working mother
- stressed worker
- construction worker
- night shift worker
- retired worker

B. Chiropractic treats the physical condition known as a Subluxation. This occurs when a bone moves from its normal position causing pain, abnormal motion and interference in the nerve communication between the brain and the body. A subluxation is defined as a misaligned bone.

Subluxations can cause malfunction in any part of the body.

Please check the health complaints you are currently experiencing:

- Stress
- Low Back Pain
- Arm/Hand Problem
- Neck Pain
- Upper/Mid Back Pain
- Leg/Foot Problem
- Ear Infections
- Asthma
- Do Not Feel Well
- Hip Pain
- Carpal Tunnel Syndrome
- Pain Across the Shoulders
- Tailbone Pain
- Knee Pain
- Headaches
- Sinus Problems

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- Allergies, Food or Pollen
- Frequent Colds/Infections
- Moodiness/Irritability
- Spinal Curvature
- Shoulder Pain
- Elbow or Wrist Pain
- Digestive Problems
- Unwanted Weight
- Fatigue
- Sleep Trouble
- Hormone Issues
- Hair Loss

Do your health complaints effect your life by causing you. . .(please check)

- additional stress
- difficulty in performing normal daily activities
- difficulty sitting
- difficulty standing
- difficulty sleeping
- difficulty getting up in the morning
- difficulty walking
- difficulty moving/exercising
- to feel fatigue
- to feel pain in other parts of your body
- lack of motivation
- inability to do what you want to do in life

Lifestyle Questions:

- Do you sleep well? Yes No Explain: _____
- Do you skip meals? Yes No Explain: _____
- Do you eat 3 meals a day? Yes No Explain: _____
- Do you drink tap water? Yes No Explain: _____

What have you tried that has not helped your health problems?

What activities would you like to do that your health is keeping you from doing? _____

How would your life change if you had optimal health? _____

What needs to happen in order for you to have optimal health, healing and wellness? _____

New Patient Health History

Who is financially responsible for this bill? _____

Method of Payment: [] Cash [] Check [] Credit Card [] Insurance

Please note: All first visit charges are payable when services are rendered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that TLC Holistic Wellness will prepare any necessary reports and forms to assist me in making collections from the insurance company, and that any amount authorized to be paid directly to TLC Holistic Wellness will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment of all charges for all services received.

Patient's Signature

Date

Guardian's Signature Authorizing Care for Minor

Date

We Respect Your Patient Privacy

I, as the patient understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. At TLC Holistic Wellness we want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you in the reception room before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature

Date

Guardian's Signature Authorizing Care for Minor

Date