ABOUT THE PATIENT

Limitless Chiropractic 1170 N. Hwy 190 Ste. 2 Covington, LA 70433

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Gender ❑ M ❑ F

e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ ph # _____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Limitless Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

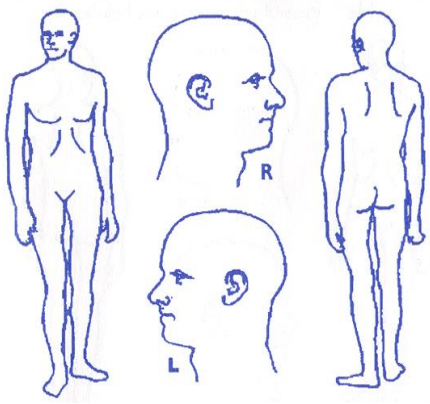
10. Results: _____

NOTES: _____

_____

_____

Please mark all areas of concern.



GENERAL HEALTH HISTORY

Limitless Chiropractic 1170 N. Hwy 190 Ste. 2 Covington, LA 70433

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Vision Problems
❑	❑	Ear Infections	❑	❑	Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches

1. **List any medications being taken:**_____

   Vaccinations: ❑ No ❑ Yes ❑ Delayed

2. **Number of courses of Antibiotics child has taken in the last 6 mo.**_____ **Total during lifetime**_____

3. **Name of Pediatrician and Other Doctors:** _____

4. **Date of Last Visit** _____/_____/_____ **Reason:**_____

5. **Name of Obstetrician/Midwife:**_____

6. **Location of Birth:** ❑ **Hospital** ❑ **Birthing Center** ❑ **Home** **Details/difficulties:**_____

7. **Birth:** ❑ **Natural w/ epidural** ❑ **Natural w/o epidural** ❑ **C-section** **Were forceps or a vacuum used?**_____

8. **At birth: Height:**_____ **Weight:**_____ **APGAR:**_____ **Weeks Gestation:**_____ **Labor hrs:**_____

9. **Complications During Pregnancy:** ❑ **No** ❑ **Yes Explain**:_____

10. **Ultrasounds During Pregnancy:** ❑ **No** ❑ **Yes How Many**:_____

11. **Medication During Pregnancy / Delivery** ❑ **No** ❑ **Yes List**:_____

12. **Cigarette / Alcohol Use during Pregnancy:** ❑ **No** ❑ **Yes**

13. **Has any Doctor/Other Professional advised you to "Take the child to a Chiropractor ":** ❑ No ❑ Yes, Name_____

PAST HISTORY

12. **List any past auto collisions:**_____ **Was any care received?**_____
13. **List any past falls bumps bruises:** _____ **Was any care received?**_____
14. **List any past sport, recreational, or home injuries:**_____
15. **Please describe any past conditions and treatment received:** _____

    _____
16. **Please list any past hospitalizations and surgeries:** _____

    _____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____