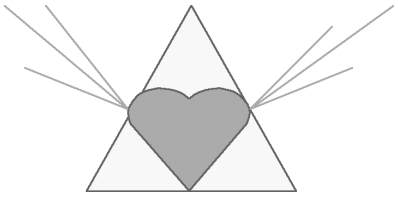


Life Source Healing Center

Dr. Becky L. Laird D.C.
1492 Prince Ave. · Athens. GA 30606 · 706-369-3600

Practice Member Information

If you need any assistance completing this form, please ask

Today's date: _____

Name: _____ Date of birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Home phone: _____ Work phone: _____

E-mail: _____ cell phone_____

Social security #: _____ ☐ Male ☐ Female Age: _____

Marital status: ☐ Married ☐ Single ☐Divorced ☐ Separated ☐ Other _____

Name of spouse/nearest relative: _____ Phone:_____

Insurance: ☐ Yes ☐ No Ins. Name _____ Address _____

Policy #_____Group#_____

Your occupation: _____ Your employer: _____

Employer's phone #: _____

Referred to this office by:☐ Friend/family member name:_____

☐ Clinic location ☐ Web / Internet ☐Phone Book ☐other :_____

Payment for services will be: ☐ Cash ☐ Check ☐ Credit card

Medical/Family History

S=Self M=Mother F=Father

S M F		S M F		S M F	
☐☐☐	AIDS	☐☐☐	Fatigue	☐☐☐	neck pain
☐☐☐	autoimmune disease	☐☐☐	fibromyalgia	☐☐☐	nervous
☐☐☐	Arthritis	☐☐☐	foot/ ankle sprains	☐☐☐	numbness
☐☐☐	Asthma	☐☐☐	Headaches	☐☐☐	pronation (fallen arches)
☐☐☐	back pain	☐☐☐	herniated disc	☐☐☐	PMS
☐☐☐	bunions	☐☐☐	heart trouble	☐☐☐	poor circulation
☐☐☐	bladder trouble	☐☐☐	reproductive disorder	☐☐☐	hepatitis
☐☐☐	bone fracture	☐☐☐	high blood pressure	☐☐☐	post menopausal
☐☐☐	cancer_____	☐☐☐	hormone problems	☐☐☐	Rheumatoid arthritis
☐☐☐	chest pain	☐☐☐	Insomnia	☐☐☐	skeletal disorders
☐☐☐	concussion	☐☐☐	kidney disorder	☐☐☐	sinus troubles
☐☐☐	convulsions	☐☐☐	menstrual pain	☐☐☐	Stroke
☐☐☐	Diabetes	☐☐☐	Multiple sclerosis	☐☐☐	thyroid disorder
☐☐☐	indigestion/GERD	☐☐☐	muscular disorders/disease	☐☐☐	gallbladder dysfunction

Describe other condition: _____

Date of last physical exam: _____

Surgical/hospitalization history:

1. _____ Date:_____
2. _____ Date: _____

Accident / Injury history: (this includes falls, sprains, hits during sports or exercise etc)

☐ Job ☐ Auto ☐ Other 1. _____ Date: _____
☐ Job ☐ Auto ☐ Other 2. _____ Date: _____
☐ Job ☐ Auto ☐ Other 3. _____ Date: _____

Current Condition of Concerns

What brought you to the office?

1. _____
2. _____
3. _____

Name and location of doctors previously seen for present concern(s): _____

_____

Have you visited a chiropractor before? ☐Yes ☐No Who? _____
When? (how long ago?)_____
How do you see your level of health?
☐ Poor ☐ Marginal ☐ Ok ☐ Good ☐ Excellent

What do you wish to achieve by coming to this office? _____

_____

_____

Are you interested in: ☐ Restoration of biomechanical balance (correction of your problems)
☐ Stress relief ☐Symptom relief (acute care only)

What type of stress(s) are you under?☐ Physical ☐ Job mental/emotional ☐Relationship/home
☐ School ☐ Auto accident ☐ Chemical/toxins ☐ Other (please explain): _____

_____

_____

_____

Do you exercise regularly? _____ What type(s)? _____
_____How often? _____
☐ Practice yoga/stretching? ☐ Meditate/pray/quiet contemplation? ☐ Tai Chi/ other discipline?
☐ Other activities that help you relieve stress? What type? _____
Do you eat vegetables regularly? _____ How many servings per day?_____
How much water do you drink? _____ Filtered? ☐Yes ☐ No
Do you drink caffeine? _____ How much? _____ What form?_____
Do you drink soft drinks? _____
Are you Vegan? _____ Vegetarian? _____ Special diet? _____ if yes what kind?_____
How would your describe you diet? _____

_____

What kinds of protein do you eat?(ie fish, meat, tofu, nuts) _____

Do you take any type of dietary supplements (herbs or vitamins)? ☐Yes ☐ No
What kind(s)? _____

_____

Are you taking any prescribed medications? ☐ Yes ☐ No
What kind(s)?_____

_____

Do you drink alcohol? ☐ Yes ☐ No How much? _____
Do you use tobacco? ☐ Yes ☐ No What kind? _____ How much? _____
Do you use recreational drugs? ☐Yes ☐ No What kind?_____How often?
Describe what daily activity you do most routinely (ie stand at work, sit at computer, bending and lifting):

_____

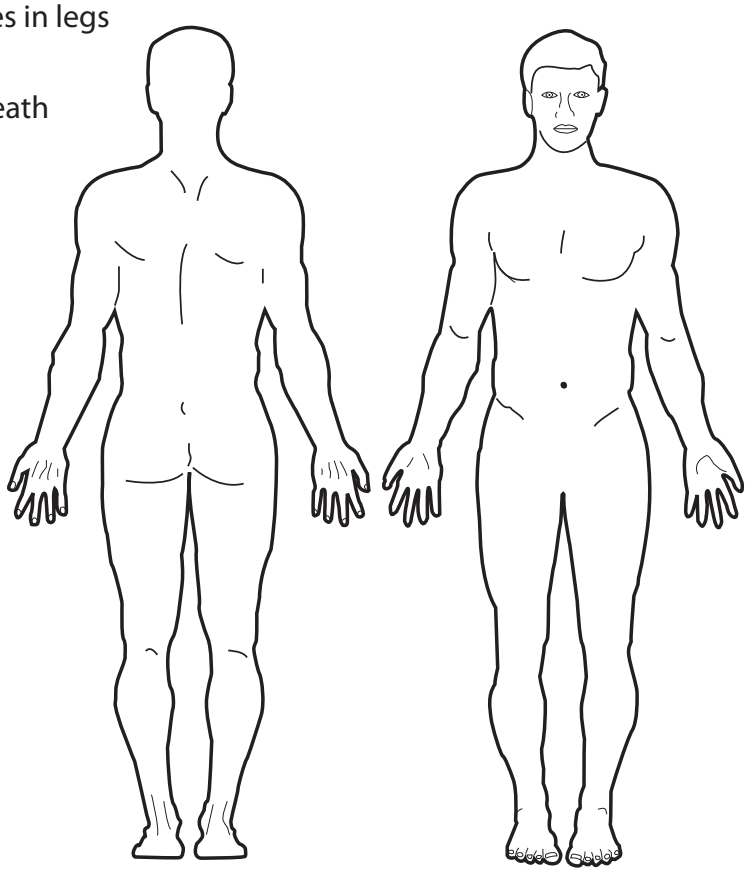
Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No
If , "Yes" what conditions?_____
Any other concerns you have:

_____

_____

_Please check any additional symptoms you may be experiencing:

☐ blurred vision
☐ buzzing in ears
☐ cold feet
☐cold sweat
☐ concentration loss/confusion
☐ constipation
☐ diarrhea
☐ dizziness
☐ night sweats
☐ depression/weeping spells
☐Knee pain
☐ fainting
☐ fever
☐ headaches
☐ head seems too heavy
☐ low resistance to colds
☐ light bothers eyes
☐ pins and needles in arms
☐ pins and needles in legs
☐ ringing in ears
☐ shortness of breath
☐ stiff neck
☐ loss of taste
☐ irritability
☐ ankle pain
☐ muscle jerking



Please circle any areas of concern:
where you have pain or discomfort

Pain Level 1 2 3 4 5 6 7 8 9 10

Are you interested in learning more about the clinical nutrition services offered by Dr. Laird? ☐ Yes ☐ No

Cancellation Policy

To my valued clients,

When I began my practice, I came to realize that it was more important to me to spend quality time with my clients versus seeing more clients, therefore I only have so many appointments available per day. For this reason, it is important for you to give me as much notice as possible when you cannot make your appointment, thus making it possible for someone else to take your time slot who may be in great need of an appointment that day.

This is why I have a 24 hour cancellation policy.

If you fail to cancel your appointment within 24 hours there will be a $25.00 fee for missed appointments. If you fail to show for you appointment without notification you will be charged for the *full amount of your visit.*

Thank you for understanding in helping me maintain the quality of care this office was established on.

Dr. Becky Laird DC

Patient's signature: _____

Disclaimer

Practice members are responsible for payment at time of initial service. A receipt can be provided, if requested for self filing of insurance claims. However, we are happy to file your insurance, in most cases, however we reserve the right to discontinue this service without notice. Any insurance you may carry is an agreement between you and your carrier. Therefore each person is solely responsible for payment of the services provided. Please understand this helps keep the cost of your care down, as well as allowing your doctor to more fully focus on you and your needs.

Patient's signature: _____

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Birth date: _____

Signature: _____ Date: _____

Records Authorization

I authorize the release of my records in order to facilitate in my treatment, file for insurance claims and coordinate through my other authorized healthcare practitioners.

Patient Signature_____ Date: _____