DR. LUKE PINATELLO
LiveProperChiropractic.com
77 Franklin Street * Westerly, RI 02891 * (401) 315-2300

WELCOME TO OUR OFFICE!

Please take a moment to fill out these forms to allow us to better understand and care for your condition,

Date_____ Name _____ E-mail _____

Address: _____
Street City State Zip

Sex: M F Age_____ Date of Birth_____ Marital Status (S) (M) (W) Other_____

Height: _____ Weight: _____ Shoe Size: _____ Shoe Width: _____

Occupation _____ Employer _____

Are you active duty military or a veteran? *(Circle one)* *Yes* *No*

Home Phone _____ Cell Phone _____

** Please send text notifications for appointment reminders and office closings (Circle one) Yes No*

IN CASE OF EMERGENCY, CONTACT:_____

Who may I thank for referring you? _____

CONSENT TO TREAT

Chiropractic care is used to remove interference caused by misalignments of spinal bones. Removing nerve interference through specific Chiropractic Adjustments is the main goal at Live Proper Chiropractic. Once the nerve system is functioning without interference you may get relief of your symptoms. This is due to the ability of the body to heal when functioning properly, without interference, due to mental, chemical, or physical stresses that act against our body during everyday living.

Maximizing your health, wellness and life through regular spinal adjustments is our primary goal. Removing Subluxations, AKA misalignments in the spine, and allowing the signals, through nerve connections between the brain and body, is necessary in order to live a healthy life.

* I do hereby authorize Live Proper Chiropractic, to release my medical records and billing records to any of its billing companies, attorneys, adjusters, etc. for the purpose of getting my bill paid.

* I do hereby authorize Live Proper Chiropractic, to release my medical records to my primary care physician and/or any other healthcare provider co-managing my health, as they deem necessary throughout the duration of my care.

* I do hereby authorize Live Proper Chiropractic, and their assistants to perform medical examination, physical therapies, spinal manipulation, and/or diagnostic testing to me today and at future office visits.

* I have been advised by Live Proper Chiropractic, that payment is due at time of each visit. I also understand that if I am not able to afford my entire visit fee, special arrangements may be made for me. However, it is my responsibility to notify Live Proper Chiropractic, of my situation.

* I have been offered / received a copy of the Notice of Privacy Practices provided by Live Proper Chiropractic. I have been provided an opportunity to review it.

I understand that Chiropractic care at Live Proper Chiropractic is for general spine wellness and is not focused on the diagnosis or treatment of specific medical conditions.

Signature: _____ Date: _____

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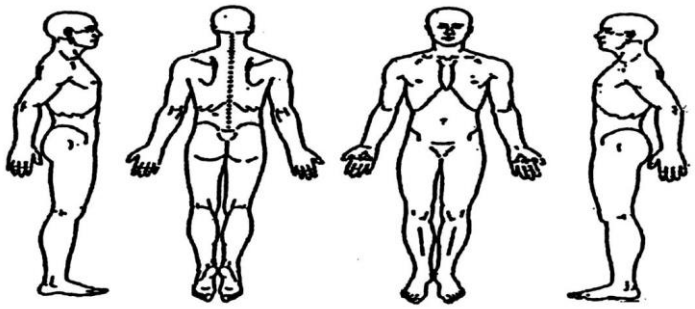
Patient Name: _____ **Today's Date:** _____

Briefly describe what brings you to our office today:_____

Indicate on the drawings to the right where you have pain/symptoms



How often do you experience your symptoms?
□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

How would you describe the type of pain?
□ Sharp □ Dull □ Diffuse □ Achy □ Burning □ Shooting □ Stiff
□ Numb □ Tingly □ Sharp with motion □ Shooting with motion □ Stabbing with motion
□ Electric like with motion □ Other:_____

How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

How much has the problem interfered with your work and social activities?
□ Not at all □ Slightly □ Moderately □ Substantially □ Extremely

Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Massage Therapist □ Physical Therapist □ No one □ Other:_____

How long have you had this problem? _____

How do you think your problem began? _____

List all medications you are currently taking: _____

List all of the vitamins/supplements you are currently taking:_____

Have you been to a Chiropractor in the past? □ No □ Yes How long ago? _____

Patient Signature_____ **Date:**_____

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Patient Name: _____ **Today's Date:** _____

Do you experience any radiating pain, numbness, or other symptoms in your arms or legs? □ No □ Yes
If yes, please explain: _____
_____

Have you ever been hospitalized or had surgeries? □ No □ Yes
If yes, please explain: _____
_____

Have you had significant past trauma? □ No □ Yes
If yes, please explain: _____
_____

Are you currently experiencing, or have you recently experienced any flu-like symptoms, cough, shortness of breath, or fever? □ No □ Yes
If yes, please explain: _____
_____

Have you recently been in contact with anyone that has experienced any flu-like symptoms, cough, shortness of breath, or fever? □ No □ Yes
If yes, please explain: _____
_____

What brings you to this office today instead of a week ago, month ago or year ago?
(Example: Is your current situation getting worse, getting frustrating, are you ready to work on your overall wellness)
_____
_____

Anything else pertinent to your visit today? □ No □ Yes
If yes, please explain: _____
_____

Patient Signature_____ **Date:**_____

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If you check "Yes" to any question below, you are most likely Subluxated and currently in need of an adjustment. It is in your best interest to have your Chiropractor check your spine as soon as possible.

1. Has it been more than 2 weeks since you were last checked for Subluxations by your Chiropractor?

□ **No** □ **Yes**

In this office, it is our purpose to check for subluxations. Subluxations reduce your ability to express your life's potential by interfering with the flow of life through your nerve system. People should be checked for subluxations beginning from birth and should continue routinely throughout their entire life.

2. Has your ability to think, sleep, work, or exercise been affected recently?

□ **No** □ **Yes**

Subluxations are most often painless and occur without symptoms. When subluxated, people can experience (but are not limited to): low energy, poor sleep, challenged breathing, reduced healing capacity, challenged digestion, challenged mental outlook.

3. Have you had any minor physical traumas such as a slip or fall?

□ **No** □ **Yes**

Subluxations can be triggered by minor physical traumas such as slips, falls, or sprains. Even healthy exercises can be equivalent to a minor trauma to your body.

4. Are you currently taking any medication?

□ **No** □ **Yes**

As currently prescribed, medications are a top leading cause of death in America. They are also a leading cause of Subluxations (Nerve system/life interference).

5. Do you have any daily mental, physical or chemical stresses?

□ **No** □ **Yes**

Stress is a leading cause of missed days of work and school. Stress is experienced daily and can be quite detrimental to your health. Some examples of stresses people face each day include, bad posture, bad diet, family issues, financial issues, working at a computer, commuting, and fear from negative stories in the news. Everyone has enough stress from their everyday life to cause a Subluxation in their spine in less than 2 weeks. In less than two weeks of having a Subluxation people can begin to experience permanent negative effects that become irreversible and health altering. This can be avoided with routine spinal checks and adjustments.

Patient Signature_____ **Date:**_____

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Patient Name: _____ Today's Date: _____

Please list your health care providers below:

Name:_____ Office:_____

Address:_____

Phone:_____ Specialty:_____

Name:_____ Office:_____

Address:_____

Phone:_____ Specialty:_____

Name:_____ Office:_____

Address:_____

Phone:_____ Specialty:_____

By signing this form, I do hereby authorize Live Proper Chiropractic Inc, to release my medical records and to discuss my patient status to contacts listed above and/or any other healthcare provider co-managing my health, as they deem necessary throughout the duration of my care.

Signature: _____ Date: _____