

## Welcome To The Living Well 4 Life Center

Welcome to our office! Be assured that you will be provided the most advanced and thorough healthcare possible. Our most important goal is the constant improvement and maintenance of your health.

The information we get from you on the following pages are important. For this reason, please fill out our history forms completely and to the best of your ability so that we can quickly get you on the road to better health. We look forward to a healthy relationships with you and your family.

*Dr. Steven Loniewski, D.C., C.C.S.P.*

# CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.  
All information you supply is confidential. We comply with all federal privacy standards.  
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Patient Number (office use only)

No  Yes

Whom may we thank for referring you?

When?

If so, whom?

Age  
Gender  
 Male  Female

Race  
 American Indian  Alaskan Native  Asian  Black or African American  
 Native Hawaiian  Other Pacific Islander  Other  White  
 Decline to answer

Ethnicity  
 Hispanic or Latino  
 Not Hispanic or Latino  
 Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

Never A Smoker  Former Smoker  
 Current Every Day Smoker  Current Some Day Smoker  
 Heavy Smoker  Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status  Married  
 Single  Divorced  
 Widowed  Separated

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes  No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone  Cell Phone  
 Work Phone  Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self  Spouse  Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

**Primary Complaint**

The primary symptom that prompted me to seek care today is: \_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury
- Work  Auto  Other \_\_\_\_\_

- A worsening long-term problem
- An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture
- Over-the-counter drugs  Chiropractic
- Homeopathic remedies  Massage
- Physical therapy  Ice
- Surgery  Heat
- Other \_\_\_\_\_

**Secondary Complaint**

The secondary symptom that prompted me to seek care today is: \_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury
- Work  Auto  Other \_\_\_\_\_

- A worsening long-term problem
- An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture
- Over-the-counter drugs  Chiropractic
- Homeopathic remedies  Massage
- Physical therapy  Ice
- Surgery  Heat
- Other \_\_\_\_\_

**Additional Complaint**

The additional symptom that prompted me to seek care today is: \_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury
- Work  Auto  Other \_\_\_\_\_

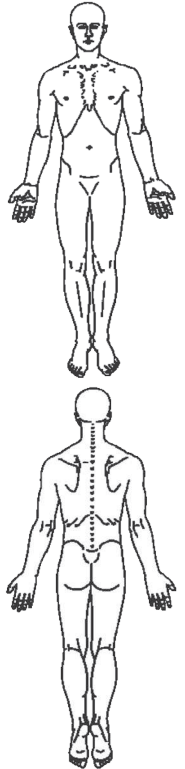
- A worsening long-term problem
- An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture
- Over-the-counter drugs  Chiropractic
- Homeopathic remedies  Massage
- Physical therapy  Ice
- Surgery  Heat
- Other \_\_\_\_\_

**Location**  
(Where does it hurt?)  
Circle the area(s) on the illustration.  
"O" for current condition  
"X" for conditions experienced in the past



1. What else should Dr. Loniewski know about your current condition? \_\_\_\_\_

2. How does your current condition interfere with your:

Work or career: \_\_\_\_\_

Recreational activities: \_\_\_\_\_

Household responsibilities: \_\_\_\_\_

Personal relationships: \_\_\_\_\_

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

- |                                                      |                                                      |                                                      |                                                      |                                                      |                                                      |                            |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis                   | <input type="radio"/> Arthritis                      | <input type="radio"/> Scoliosis                      | <input type="radio"/> Neck pain                      | <input type="radio"/> Back problems                  | <input type="radio"/> Hip disorders                  | Initials _____             |
| <input type="radio"/> Knee injuries                  | <input type="radio"/> Foot/ankle pain                | <input type="radio"/> Shoulder problems              | <input type="radio"/> Elbow/wrist pain               | <input type="radio"/> TMJ issues                     | <input type="radio"/> Poor posture                   |                            |

b. Neurological

- |                                                      |                                                      |                                                      |                                                      |                                                      |                                                      |                            |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety                        | <input type="radio"/> Depression                     | <input type="radio"/> Headache                       | <input type="radio"/> Dizziness                      | <input type="radio"/> Pins and needles               | <input type="radio"/> Numbness                       | Initials _____             |

c. Cardiovascular

- |                                                      |                                                      |                                                      |                                                      |                                                      |                                                      |                            |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure            | <input type="radio"/> Low blood pressure             | <input type="radio"/> High cholesterol               | <input type="radio"/> Poor circulation               | <input type="radio"/> Angina                         | <input type="radio"/> Excessive bruising             | Initials _____             |

d. Respiratory

- |                                                      |                                                      |                                                      |                                                      |                                                      |                                                      |                            |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma                         | <input type="radio"/> Apnea                          | <input type="radio"/> Emphysema                      | <input type="radio"/> Hay fever                      | <input type="radio"/> Shortness of breath            | <input type="radio"/> Pneumonia                      | Initials _____             |

e. Digestive

- |                                                      |                                                      |                                                      |                                                      |                                                      |                                                      |                            |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia               | <input type="radio"/> Ulcer                          | <input type="radio"/> Food sensitivities             | <input type="radio"/> Heartburn                      | <input type="radio"/> Constipation                   | <input type="radio"/> Diarrhea                       | Initials _____             |

f. Sensory

- |                                                      |                                                      |                                                      |                                                      |                                                      |                                                      |                            |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision                 | <input type="radio"/> Ringing in ears                | <input type="radio"/> Hearing loss                   | <input type="radio"/> Chronic ear infection          | <input type="radio"/> Loss of smell                  | <input type="radio"/> Loss of taste                  | Initials _____             |

g. Skin

- |                                                      |                                                      |                                                      |                                                      |                                                      |                                                      |                            |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Skin cancer                    | <input type="radio"/> Psoriasis                      | <input type="radio"/> Eczema                         | <input type="radio"/> Acne                           | <input type="radio"/> Hair loss                      | <input type="radio"/> Rash                           | Initials _____             |

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Patient Number  
(office use only)

\_\_\_\_\_  
Doctor's Initials

Living Well 4 Life Center  
Dr. Steven Loniewski, D.C.

(Continued from previous page)

**h. Endocrine**

- |                                                      |                                                      |                                                      |                                                      |                                                      |                                                      |                            |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Thyroid issues                 | <input type="radio"/> Immune disorders               | <input type="radio"/> Hypoglycemia                   | <input type="radio"/> Frequent infection             | <input type="radio"/> Swollen glands                 | <input type="radio"/> Low energy                     | Initials _____             |

**i. Genitourinary**

- |                                                      |                                                      |                                                      |                                                      |                                                      |                                    |                |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------|----------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/>         |                |
| <input type="radio"/> Kidney stones                  | <input type="radio"/> Infertility                    | <input type="radio"/> Bedwetting                     | <input type="radio"/> Prostate issues                | <input type="radio"/> Erectile dysfunction           | <input type="radio"/> PMS symptoms | Initials _____ |

**j. Constitutional**

- |                                                      |                                                      |                                                      |                                                      |                                                            |                                                      |                            |
|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/>       | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Fainting                       | <input type="radio"/> Low libido                     | <input type="radio"/> Poor appetite                  | <input type="radio"/> Fatigue                        | <input type="radio"/> Sudden weight gain/loss (circle one) | <input type="radio"/> Weakness                       | Initials _____             |

Patient name \_\_\_\_\_

Initials \_\_\_\_\_

Patient Number (office use only)

All other systems negative

**Past Personal, Family and Social History**

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL	<b>4. Illnesses</b> Check the illnesses you have <b>Had</b> in the past or <b>Have</b> now.	<b>5. Operations</b> Surgical interventions, which may or may not have included hospitalization.	<b>6. Treatments</b> Check the ones you've received in the <b>Past</b> or are receiving <b>Currently</b> .
	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Past <input type="radio"/> Currently <input type="radio"/>
	<input type="radio"/> AIDS	<input type="radio"/> Tuberculosis	<input type="radio"/> Acupuncture
	<input type="radio"/> Alcoholism	<input type="radio"/> Typhoid fever	<input type="radio"/> Antibiotics
	<input type="radio"/> Allergies	<input type="radio"/> Ulcer	<input type="radio"/> Birth control pills
	<input type="radio"/> Arteriosclerosis	<input type="radio"/> Other: _____	<input type="radio"/> Blood transfusions
	<input type="radio"/> Cancer		<input type="radio"/> Chemotherapy
	<input type="radio"/> Chicken pox		<input type="radio"/> Chiropractic care
	<input type="radio"/> Diabetes	<b>7. Allergies</b>	<input type="radio"/> Dialysis
	<input type="radio"/> Epilepsy	Are you allergic to any medications?	<input type="radio"/> Herbs
	<input type="radio"/> Glaucoma	Yes <input type="radio"/> No <input type="radio"/>	<input type="radio"/> Homeopathy
	<input type="radio"/> Goiter	<input type="radio"/> If Yes please list: _____	<input type="radio"/> Hormone replacement
	<input type="radio"/> Gout		<input type="radio"/> Inhaler
	<input type="radio"/> Heart disease		<input type="radio"/> Massage therapy
	<input type="radio"/> Hepatitis		<input type="radio"/> Physical therapy
<input type="radio"/> HIV Positive		<input type="radio"/> Medications	
<input type="radio"/> Malaria		(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):	
<input type="radio"/> Measles		_____	
<input type="radio"/> Multiple Sclerosis		_____	
<input type="radio"/> Mumps		_____	
<input type="radio"/> Polio		_____	
<input type="radio"/> Rheumatic fever	<b>8. Injuries</b>	_____	
<input type="radio"/> Scarlet fever	Have you ever...	_____	
<input type="radio"/> Sexually transmitted disease	<input type="radio"/> Had a fractured or broken bone	<input type="radio"/> Used a crutch or other support	
<input type="radio"/> Stroke	<input type="radio"/> Had a spine or nerve disorder	<input type="radio"/> Used neck or back bracing	
	<input type="radio"/> Been knocked unconscious	<input type="radio"/> Received a tattoo	
	<input type="radio"/> Been injured in an accident	<input type="radio"/> Had a body piercing	

Consultation Notes

**9. Family History**

Some health issues are hereditary. Tell Dr. Loniewski about the health of your immediate family members.

FAMILY	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	_____	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

**10. Are there any other hereditary health issues that you know about?** \_\_\_\_\_

**11. Social History**

Tell Dr. Loniewski about your health habits and stress levels.

SOCIAL	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
	Hobbies:	_____			

Doctor's Initials \_\_\_\_\_

**Living Well 4 Life Center  
Dr. Steven Loniewski, D.C.**

**12. Activities of Daily Living**

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name \_\_\_\_\_

Patient Number  
(office use only)

13. What is the major stressor in your life? \_\_\_\_\_ 14. How much sleep do you average per night? \_\_\_\_\_ Hours

15. What is the type and approximate age of your mattress and pillow? \_\_\_\_\_ 16. What is your preferred sleeping position? \_\_\_\_\_

17. Describe your typical eating habits:  Skip breakfast  Two meals a day  Three meals a day  Snacking between meals

18. What would be the most significant thing that you could do to improve your health? \_\_\_\_\_

19. In addition to the main reason for your visit today, what additional health goals do you have? \_\_\_\_\_

**Acknowledgements**

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials \_\_\_\_\_ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials \_\_\_\_\_ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials \_\_\_\_\_ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): \_\_\_\_\_**

Initials \_\_\_\_\_ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials \_\_\_\_\_ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials \_\_\_\_\_ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Consultation Notes

Doctor's Initials \_\_\_\_\_

Living Well 4 Life Center  
Dr. Steven Loniewski, D.C.

\_\_\_\_\_  
Patient (or Guardian's) signature

\_\_\_\_\_  
Date (MM/DD/YYYY)