

**LIFECARE
CHIROPRACTIC**

PATIENT INFORMATION:

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Emergency Phone: (____) _____ - _____

Date of Birth: _____ Social Security #: _____ Sex: M _____ F _____

Marital Status: _____ Spouse's Name: _____ Children # : _____

Person Responsible for Payment: _____

EMPLOYER INFORMATION

Please Check One: Patient's Employer _____ Responsible Party's Employer _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Please indicate how you heard about our clinic and tell us the name of your source:

() Referring Physician: _____ () Patient: _____

() Newspaper: _____ () Phone Directory: _____

() Student: _____ () Health Screen – Location _____

() Drove by Clinic: _____ () Other: _____

I understand and agree that I am financially responsible for the services that I receive from Lifecare Chiropractic, Inc ("Lifecare Chiropractic "). If a person is designated above as "Person Responsible for Payment," such person may also be responsible for payment, but that designation does not affect my agreement to pay for the services that I receive from Lifecare Chiropractic. If I fail to pay for the services that I receive from Lifecare Chiropractic within 30 days, I expressly agree to pay all costs of collection, including, but not limited to attorneys' fees and taxable and non-taxable costs. I agree to pay for the services that I receive from Lifecare Chiropractic in the following manner:

Cash _____ Check _____ Visa _____ Mastercard _____

Also, I hereby authorize the physician to diagnose and treat me (or my dependent/minor child), and to take those x-rays that are clinically indicated.

Patient's Signature: _____ Date: _____

(or Patient's Parent/Guardian, if Minor)

Patient # : _____

Patient Health Questionnaire

Patient Name _____ **Date** _____

File number _____

1) Describe your symptoms: _____

2) When did your symptoms begin? _____

3) How did your symptoms begin? _____

4) What makes your symptoms worse (activities, positions, etc...)? _____

5) What makes your symptoms better (activities, positions, medications, etc...)? _____

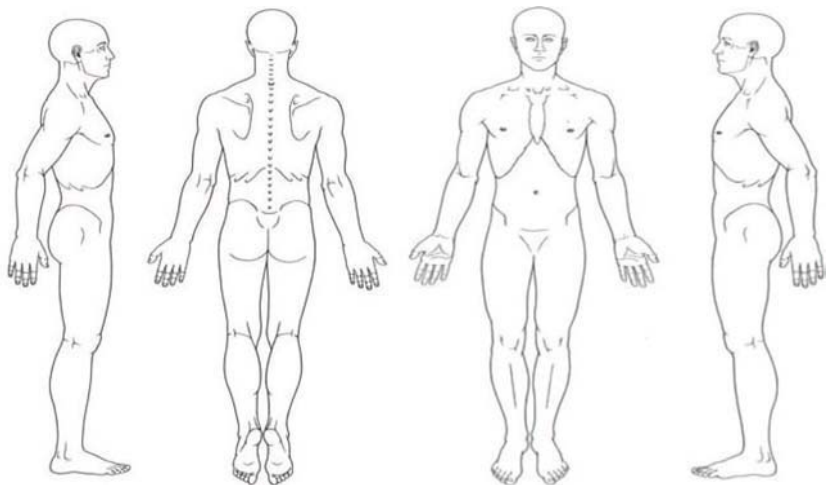
6) How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Intermittently (26-50% of the day)
- Occasionally (0-25% of the day)

7) What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling

8) Indicate where you have pain or other symptoms below



9) How are your symptoms changing?

- Getting better
- Staying the same
- Getting worse

9) Please mark an "X" at the position on the scale to indicate how much pain you feel at this time for each location of pain you are experiencing:

no pain _____ worst pain imaginable

Location:

no pain _____ worst pain imaginable

Location:

no pain _____ worst pain imaginable

Location:

10) How much has pain interfered w/ normal work (work both inside or outside the home)

- Not at all A little bit Moderately Quite a bit Extremely

11) During the past 4 weeks, how much of the time has your condition interfered with your social activities such as visiting with friends, hobbies, exercise?

- All of the time Most of the time Some of the time A little of the time None of the time

12) In general, how would you currently rate your overall health?

- Excellent Very Good Good Fair Poor

13) Who have you seen for your symptoms? No one Medical doctor Chiropractor
 Physical Therapist Other

a) What treatment did you receive and when? _____

b) What tests have you had performed and approx when? MRI _____ CT scan _____
 X rays _____ Blood
work _____
 Other _____

14) Have you had similar symptoms in the past? Yes No

a) If you have received treatment for similar symptoms in the past, what kind of provider did you see?

- This office Chiropractor Medical doctor Physical Therapist
 Massage Therapist Other

Patient Signature _____ Date _____

CONFIDENTIAL HEALTH HISTORY

The items below may relate to your current condition. Please place a check in the column if you are currently troubled or if you have ever had a particular symptom.

<p><u>General</u></p> <p><input type="checkbox"/> 01 Abnormal weight loss/gain</p> <p><input type="checkbox"/> 02 Alcoholism/drug abuse</p> <p><input type="checkbox"/> 03 Allergies</p> <p><input type="checkbox"/> 04 Blood/bleeding problems</p> <p><input type="checkbox"/> 05 Breast lumps/soreness</p> <p><input type="checkbox"/> 06 Cancer</p> <p><input type="checkbox"/> 07 Depression/anxiety</p> <p><input type="checkbox"/> 08 Diabetes</p> <p><input type="checkbox"/> 09 Excessive thirst</p> <p><input type="checkbox"/> 10 Fever/chills without flu)</p> <p><input type="checkbox"/> 11 General fatigue</p> <p><input type="checkbox"/> 12 Night sweats</p> <p><input type="checkbox"/> 13 Poor sleep</p> <p><input type="checkbox"/> 14 Thyroid disease/goiter</p> <p><u>Gastrointestinal</u></p> <p><input type="checkbox"/> 15 Abdominal pain</p> <p><input type="checkbox"/> 16 Appendicitis</p> <p><input type="checkbox"/> 17 Belching/gas</p> <p><input type="checkbox"/> 18 Black//bloody stools</p> <p><input type="checkbox"/> 19 Constipation</p> <p><input type="checkbox"/> 20 Diarrhea</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/> 22 Gallbladder problems</p> <p><input type="checkbox"/> 23 Hemorrhoids</p> <p><input type="checkbox"/> 24 Hernia</p> <p><input type="checkbox"/> 25 Liver problems/jaundice</p> <p><input type="checkbox"/> 26 Frequent nausea/vomiting</p> <p><input type="checkbox"/> 27 Pain over abdomen</p> <p><input type="checkbox"/> 28 Poor appetite</p> <p><input type="checkbox"/> 29 Poor Digestion</p> <p><input type="checkbox"/> 30 Ulcer/heartburn</p> <p><u>Eye, Ear, Nose and Throat</u></p> <p><input type="checkbox"/> 31 Deafness/difficulty hearing</p> <p><input type="checkbox"/> 32 Dental problems</p> <p><input type="checkbox"/> 33 Ear noises/ringing</p> <p><input type="checkbox"/> 34 Hoarseness</p> <p><input type="checkbox"/> 35 Nosebleeds</p> <p><input type="checkbox"/> 36 Nose problems</p> <p><input type="checkbox"/> 37 Pain in/behind eyes</p> <p><input type="checkbox"/> 38 Sinus problems/hay fever</p> <p><input type="checkbox"/> 39 TMJ/other jaw pain</p> <p><input type="checkbox"/> 40 Tonsillectomy</p> <p><input type="checkbox"/> 41 Visual disturbances</p>	<p><u>Cardio-Respiratory</u></p> <p><input type="checkbox"/> 42 Ankle swelling</p> <p><input type="checkbox"/> 43 Asthma/wheezing</p> <p><input type="checkbox"/> 44 Chest pains</p> <p><input type="checkbox"/> 45 Chronic cough</p> <p><input type="checkbox"/> 46 Difficulty breathing</p> <p><input type="checkbox"/> 47 Emphysema</p> <p><input type="checkbox"/> 48 High blood pressure</p> <p><input type="checkbox"/> 49 High cholesterol levels</p> <p><input type="checkbox"/> 50 Irregular heartbeat</p> <p><input type="checkbox"/> 51 Previous heart trouble</p> <p><input type="checkbox"/> 52 Rheumatic fever</p> <p><input type="checkbox"/> 53 Spitting phlegm/blood</p> <p><input type="checkbox"/> 54 Stroke</p> <p><input type="checkbox"/> 55 Tuberculosis</p> <p><input type="checkbox"/> 56 Varicose veins</p> <p><u>Skin</u></p> <p><input type="checkbox"/> 57 Bruising easily</p> <p><input type="checkbox"/> 58 Change in mole(s)</p> <p><input type="checkbox"/> 59 Itching/eczema/rash</p> <p><input type="checkbox"/> 60 Skin cancer</p> <p><u>Genitourinary</u></p> <p><input type="checkbox"/> 61 Blood in urine</p> <p><input type="checkbox"/> 62 Difficulty starting flow</p> <p><input type="checkbox"/> 63 Frequent urination</p> <p><input type="checkbox"/> 64 Frequent night urination</p> <p><input type="checkbox"/> 65 Inability to control flow</p> <p><input type="checkbox"/> 66 Kidney disease/stones</p> <p><input type="checkbox"/> 67 Painful urination</p> <p><input type="checkbox"/> 68 Sexual difficulties</p> <p><input type="checkbox"/> 69 Urinary tract infection</p> <p><input type="checkbox"/> 70 Venereal infection</p> <p><u>Women Only</u></p> <p><input type="checkbox"/> 71 Endometriosis</p> <p><input type="checkbox"/> 72 Excessive flow</p> <p><input type="checkbox"/> 73 Irregular cycles</p> <p><input type="checkbox"/> 74 Hot Flashes</p> <p><input type="checkbox"/> 75 Painful periods</p> <p><input type="checkbox"/> 76 PMS</p> <p><input type="checkbox"/> 77 Pregnancy - # of births__</p> <p><input type="checkbox"/> 78 Vaginal burning/itching</p> <p><input type="checkbox"/> 79 Date last period began _____</p> <p><input type="checkbox"/> 80 Date of last PAP Test _____</p>	<p><u>Men Only</u></p> <p><input type="checkbox"/> 81 Testicular swelling/pain</p> <p><input type="checkbox"/> 82 Prostate problems</p> <p><u>Neurological</u></p> <p><input type="checkbox"/> 83 Convulsions</p> <p><input type="checkbox"/> 84 Dizziness</p> <p><input type="checkbox"/> 85 Fainting</p> <p><input type="checkbox"/> 86 Headache</p> <p><input type="checkbox"/> 87 Mental disorder</p> <p><input type="checkbox"/> 88 Numbness/tingling</p> <p><input type="checkbox"/> 89 Twitching/tremors/epilepsy</p> <p><input type="checkbox"/> 90 Weakness</p> <p><u>Musculoskeletal</u></p> <p><input type="checkbox"/> 91 Neck stiffness/pain</p> <p><input type="checkbox"/> 92 Pain between shoulders</p> <p><input type="checkbox"/> 93 Low back pain</p> <p><input type="checkbox"/> 94 Hip/knee/ankle/foot pain</p> <p><input type="checkbox"/> 95 Osteoporosis</p> <p><input type="checkbox"/> 96 Rheumatoid arthritis</p> <p><input type="checkbox"/> 97 Shoulder/elbow/wrist/hand pain</p> <p><input type="checkbox"/> 98 Scoliosis</p> <p><u>Habits</u></p> <p><input type="checkbox"/> 99 Smoking __ packs/day</p> <p><input type="checkbox"/> 100 Drinking</p> <p><input type="checkbox"/> 101 Exercise __ days/week</p> <p><input type="checkbox"/> 102 Recreational drug use</p> <p><u>Family History</u> (brothers, sisters, parents, grandparents only, not yourself)</p> <p><input type="checkbox"/> 103 Cancer</p> <p><input type="checkbox"/> 104 Diabetes</p> <p><input type="checkbox"/> 105 High blood pressure</p> <p><input type="checkbox"/> 106 Heart disease/stroke</p> <p><input type="checkbox"/> 107 Kidney disease</p> <p><input type="checkbox"/> 108 Muscle, bone, nerve disease</p> <p><input type="checkbox"/> 109 Thyroid disease</p> <p>Pt Name: : _____</p> <p>Pt File No: _____</p>
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Lifecare Chiropractic



1830 S. Alma School Rd #135 ♦ Mesa, AZ 85210
Phone (480) 839-2273 ♦ www.lifecarechiro.com

What are your objectives in coming to this office (i.e. pain relief, long term wellness, etc...)

When was the last time a physician put you on a lifestyle or disease management program?

Are you healthier now then you were 5 years ago? Y N

If yes, what have you done to improve your health?

Do you expect that you will be healthier in 5 years? Y N

If yes, what will you do to achieve this goal?

If no, what do you think you could do better?

Office use only – do not write below this line

Patient objectives

Temporary relief _____

Correction _____

Maintenance _____

Lifestyle Wellness _____

Patient goals:

Patient Name _____

File Number _____