

**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...)? _____

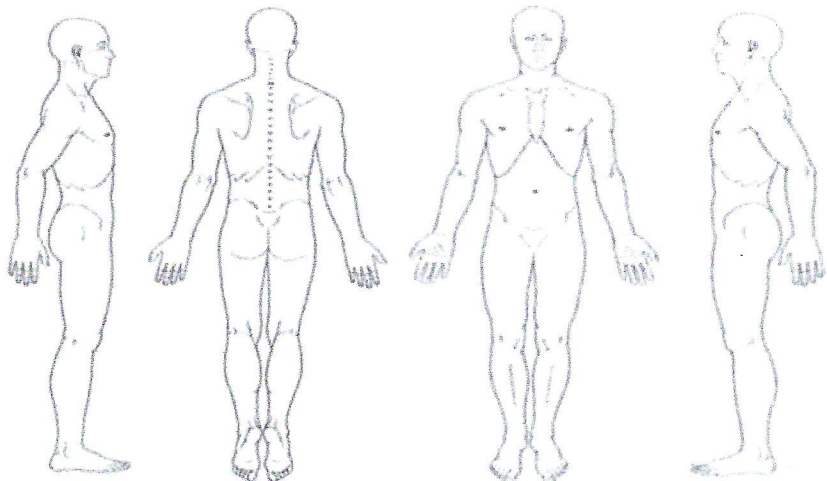
6) How often do you experience your symptoms?

- 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**Pt Name:** _____**Pt File No:** _____

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"/> 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>_____</p> <p>Height:: _____</p> <p>Weight:: _____</p>
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Lifecare Chiropractic



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

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?

Many patients that come into our office either have a chronic disease (high cholesterol, osteoporosis, diabetes, heart disease, high blood pressure, etc.,) or have a family history that has concerned them (Alzheimer's, cancer, diabetes, Parkinson's, etc...).

Both Dr. Bogash and Dr. Arlt are very knowledgeable in guiding patients towards healthier lifestyles as well as powerful supplements that may help lower your risk of chronic disease. Lifestyle changes are the best answer to chronic disease, but they require a much greater investment on the part of the patient. We understand that not every patient is willing to make this type of involvement at this time. In order for us to meet you where you are at, please circle which category you fall into.

- A) I am interested and willing to make lifestyle changes (diet, exercise, stress management) to improve my health and lower my risk.
- B) I'm not that excited about lifestyle changes. I am however, interested in purchasing supplements that can help improve my health and lower my risk of serious disease. I understand that this is NOT the optimal way, but I want to do something to improve my health status.
- C) At this time, I have no interest in either supplements or lifestyle changes to improve my health.

Patient Name: _____

File Number: _____

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ERISA ASSIGNMENT FORM

I assign the right to payment for all medical benefits directly to James Bogash, DC or Charles Everts, DC in consideration for medical services and supplies provided pursuant to my health insurance plan.

In the event my health insurance plan refuses to pay for provided, medically necessary services, I also assign all my ERISA* rights to James Bogash, DC or Charles Everts, DC for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for faulty claims processing. This ERISA assignment is in consideration for the unpaid services provided, in consideration for my insurance plan's reduced fee schedule, and in consideration for the continued willingness of James Bogash, DC or Charles Everts, DC to see patients, including myself, on an insurance assignment basis. I understand that if my treating doctor prevails in any such payment dispute, I may be liable for co-payment for the contested services.

I give consent to release medical information to James Bogash, DC or Charles Everts, DC. I give consent to James Bogash, DC or Charles Everts, DC to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to James Bogash, DC or Charles Everts, DC to send medical information, as necessary to my insurance company.

*ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts up to \$110 a day for each infraction.

Patient's printed name _____

Patient's signature _____ Date _____