

**LIFECARE
CHIROPRACTIC**

PATIENT INFORMATION:

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

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: () - _____ Work Phone: () - _____ Cell/Emergency: () - _____

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

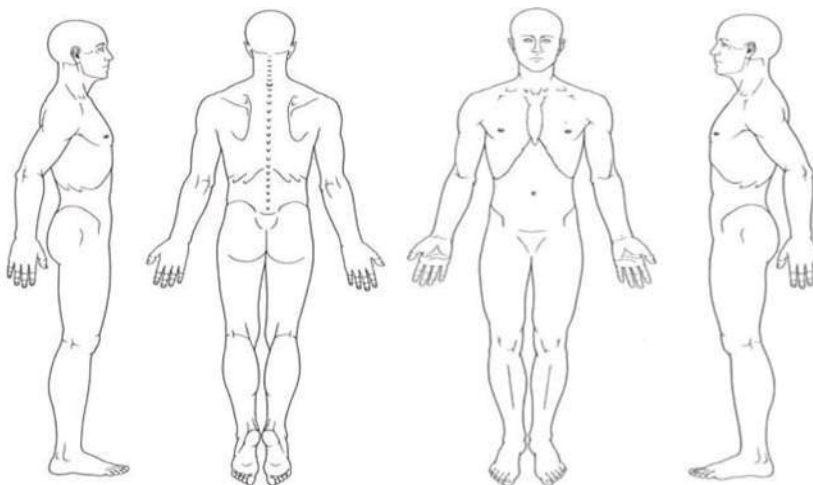
Numb

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>01Abnormal weight loss/gain 02Alcoholism/drug abuse 03Allergies 04Blood/bleeding problems 05Breast lumps/soreness 06Cancer 07Depression/anxiety 08Diabetes 09Excessive thirst 10Fever/chills without flu) 11General fatigue 12Night sweats 13Poor sleep 14Thyroid disease/goiter</p> <p><u>Gastrointestinal</u></p> <p>15Abdominal pain 16Appendicitis 17Belching/gas 18Black//bloody stools 19Constipation 20Diarrhea</p> <p>22Gallbladder problems 23Hemorrhoids 24Hernia 25Liver problems/jaundice 26Frequent nausea/vomiting 27Pain over abdomen 28Poor appetite 29Poor Digestion 30Ulcer/heartburn</p> <p><u>Eye, Ear, Nose and Throat</u></p> <p>31Deafness/difficulty hearing 32Dental problems 33Ear noises/ringing 34Hoarseness 35Nosebleeds 36Nose problems 37Pain in/behind eyes 38Sinus problems/hay fever 39TMJ/other jaw pain 40Tonsillectomy 41Visual disturbances</p>	<p><u>Cardio-Respiratory</u></p> <p>42Ankle swelling 43Asthma/wheezing 44Chest pains 45Chronic cough 46Difficulty breathing 47Emphysema 48High blood pressure 49High cholesterol levels 50Irregular heartbeat 51Previous heart trouble 52Rheumatic fever 53Spitting phlegm/blood 54Stroke 55Tuberculosis 56Varicose veins</p> <p><u>Skin</u></p> <p>57Bruising easily 58Change in mole(s) 59Itching/eczema/rash 60Skin cancer</p> <p><u>Genitourinary</u></p> <p>61Blood in urine 62Difficulty starting flow 63Frequent urination 64Frequent night urination 65Inability to control flow 66Kidney disease/stones 67Painful urination 68Sexual difficulties 69Urinary tract infection 70Venereal infection</p> <p><u>Women Only</u></p> <p>71Endometriosis 72Excessive flow 73Irregular cycles 74Hot Flashes 75Painful periods 76PMS 77Pregnancy - # of births____ 78Vaginal burning/itching 79Date last period began _____ 80Date of last PAP Test _____</p>	<p><u>Men Only</u></p> <p>81Testicular swelling/pain 82Prostate problems</p> <p><u>Neurological</u></p> <p>83Convulsions 84Dizziness 85Fainting 86Headache 87Mental disorder 88Numbness/tingling 89Twitching/tremors/epilepsy 90Weakness</p> <p><u>Musculoskeletal</u></p> <p>91Neck stiffness/pain 92Pain between shoulders 93Low back pain 94Hip/knee/ankle/foot pain 95Osteoporosis 96Rheumatoid arthritis 97Shoulder/elbow/wrist/hand pain 98Scoliosis</p> <p><u>Habits</u></p> <p>99Smoking __ packs/day 100Drinking 101Exercise __ days/week 102Recreational drug use</p> <p><u>Family History</u> (brothers, sisters, parents, grandparents only, not yourself)</p> <p>103Cancer 104Diabetes 105High blood pressure 106Heart disease/stroke 107Kidney disease 108Muscle, bone, nerve disease 109Thyroid disease</p> <p>Pt Name: : _____ 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 _____

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

- 0 = Not experienced at all
- 1 = No more of a problem
- 2 = A mild problem
- 3 = A moderate problem
- 4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches.....	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity,					
easily upset by loud noise	0	1	2	3	4
Sleep Disturbance.....	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity,					
Easily upset by bright light.....	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

- 1. _____ 0 1 2 3 4
- 2. _____ 0 1 2 3 4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your WORK because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> I go to work but work in pain | <input type="checkbox"/> I work in pain because I have bills to pay |
| <input type="checkbox"/> I limit my work activities | <input type="checkbox"/> I can't take time off because I would lose my job |
| <input type="checkbox"/> Bending at work hurts | <input type="checkbox"/> I keep working so I don't lose status at company |
| <input type="checkbox"/> Stooping at work hurts | <input type="checkbox"/> My business would fail if I took time off |
| <input type="checkbox"/> Sitting at work hurts | <input type="checkbox"/> I believe in working even when I'm in pain |
| <input type="checkbox"/> Using the Computer at work hurts | <input type="checkbox"/> I feel obligated to work even though I'm in pain |
| <input type="checkbox"/> Pushing at work hurts | <input type="checkbox"/> My business would lose money if I took time off |
| <input type="checkbox"/> Pulling at work hurts | <input type="checkbox"/> My work is not as good as it was before accident |
| <input type="checkbox"/> Kneeling at work hurts | <input type="checkbox"/> My boss reprimanded me for poor performance |
| <input type="checkbox"/> I have lost status in my company | <input type="checkbox"/> I got a different job within the same company |
| <input type="checkbox"/> I have lost job security | <input type="checkbox"/> I got a different job in another company |
| <input type="checkbox"/> I didn't get a promotion | <input type="checkbox"/> I make less money than before the accident |
| <input type="checkbox"/> I don't enjoy work as much as before | <input type="checkbox"/> I cannot do the same work/job as before accident |
| <input type="checkbox"/> I doze off at work | <input type="checkbox"/> I can't concentrate as well at work |
| <input type="checkbox"/> I take unpaid time off work to go to Dr. | <input type="checkbox"/> I take paid time off to go to Dr. |
| <input type="checkbox"/> I daydream at work more than before | <input type="checkbox"/> I make mistakes at work I didn't used to |
| <input type="checkbox"/> I feel tired at work | <input type="checkbox"/> I hide my poor work performance from my boss |
| <input type="checkbox"/> I need medication to be able to work. I take _____ mg of _____ at _____ am
when my pain level gets to ____/10 and/or again at _____ pm when my pain gets to ____/10 | |

Please check all that apply to your HOME/DOMESTIC duties because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> My house is not as clean now | <input type="checkbox"/> I cannot take time off because I care for children |
| <input type="checkbox"/> My yard is not as neat now | <input type="checkbox"/> I have _____ children ages _____ |
| <input type="checkbox"/> My garden is not as productive now | <input type="checkbox"/> I had to hire a paid housekeeper |
| <input type="checkbox"/> I do yard work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid housekeeping help |
| <input type="checkbox"/> I cannot do my normal yard work | <input type="checkbox"/> I had to hire a paid gardener |
| <input type="checkbox"/> I do house work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid yard work help |
| <input type="checkbox"/> I cannot do my normal house work | <input type="checkbox"/> Mowing the lawn hurts me |
| <input type="checkbox"/> Doing laundry hurts me | <input type="checkbox"/> I cannot mow the lawn |
| <input type="checkbox"/> I cannot do laundry now | <input type="checkbox"/> Taking out the trash hurts me |
| <input type="checkbox"/> Washing dishes hurts me | <input type="checkbox"/> I cannot take out the trash |
| <input type="checkbox"/> I cannot wash dishes now | <input type="checkbox"/> I do not enjoy my gardening/yardwork like I used to |
| <input type="checkbox"/> Vacuuming hurts me | <input type="checkbox"/> I do not enjoy my housework like I used to |
| <input type="checkbox"/> I cannot vacuum now | <input type="checkbox"/> Gardening hurts me |
| <input type="checkbox"/> Cooking hurts me | <input type="checkbox"/> I cannot do my gardening at all since the accident |
| <input type="checkbox"/> I cannot cook now | <input type="checkbox"/> Others living with me do my share of the work now |
| <input type="checkbox"/> Washing the car hurts me | <input type="checkbox"/> Others living with me do my share of the yard work |
| <input type="checkbox"/> I cannot wash my car | <input type="checkbox"/> Others living with me do my share of the gardening |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Signature _____

Date _____