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…)? _____

_____

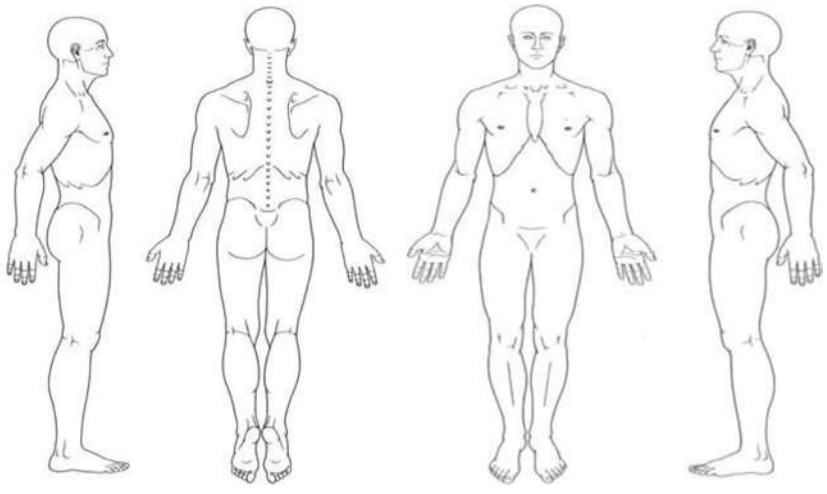
6) How often do you experience your symptoms?

- ○ 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.

General

- ☐ 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

Gastrointestinal

- ☐ 15Abdominal pain
- ☐ 16Appendicitis
- ☐ 17Belching/gas
- ☐ 18Black//bloody stools
- ☐ 19Constipation
- ☐ 20Diarrhea
- ☐ 22Gallbladder problems
- ☐ 23Hemorrhoids
- ☐ 24Hernia
- ☐ 25Liver problems/jaundice
- ☐ 26Frequent nausea/vomiting
- ☐ 27Pain over abdomen
- ☐ 28Poor appetite
- ☐ 29Poor Digestion
- ☐ 30Ulcer/heartburn

Eye, Ear, Nose and Throat

- ☐ 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

Cardio-Respiratory

- ☐ 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

Skin

- ☐ 57Bruising easily
- ☐ 58Change in mole(s)
- ☐ 59Itching/eczema/rash
- ☐ 60Skin cancer

Genitourinary

- ☐ 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

Women Only

- ☐ 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 _____

Men Only

- ☐ 81Testicular swelling/pain
- ☐ 82Prostate problems

Neurological

- ☐ 83Convulsions
- ☐ 84Dizziness
- ☐ 85Fainting
- ☐ 86Headache
- ☐ 87Mental disorder
- ☐ 88Numbness/tingling
- ☐ 89Twitching/tremors/epilepsy
- ☐ 90Weakness

Musculoskeletal

- ☐ 91Neck stiffness/pain
- ☐ 92Pain between shoulders
- ☐ 93Low back pain
- ☐ 94Hip/knee/ankle/foot pain
- ☐ 95Osteoporosis
- ☐ 96Rheumatoid arthritis
- ☐ 97Shoulder/elbow/wrist/hand pain
- ☐ 98Scoliosis

Habits

- ☐ 99Smoking __ packs/day
- ☐ 100Drinking
- ☐ 101Exercise __ days/week
- ☐ 102Recreational drug use

Family History

(brothers, sisters, parents, grandparents only, not yourself)

- ☐ 103Cancer
- ☐ 104Diabetes
- ☐ 105High blood pressure
- ☐ 106Heart disease/stroke
- ☐ 107Kidney disease
- ☐ 108Muscle, bone, nerve disease
- ☐ 109Thyroid disease

Pt Name: :_____
Pt File No:_____

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 _____

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Phone (480) 839-2273 ♦ Fax (480) 907-3061 ♦ www.lifecarechiro.com

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_____