

**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...)? _____

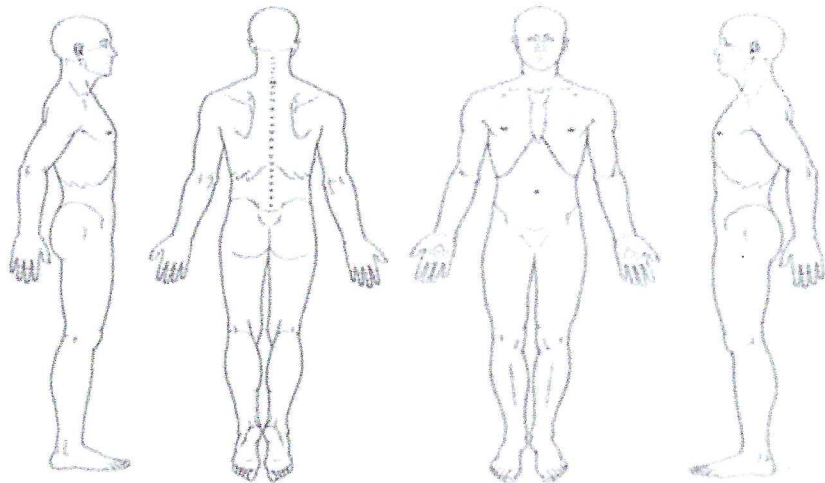
6) How often do you experience your symptoms?

- 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.

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

Lifecare Chiropractic



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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: _____

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.

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

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

Signature _____

Date _____