LIFE SPRING CHIROPRACTIC

NEW CHIROPRACTIC PATIENT QUESTIONNAIRE

Patient# _____ Date _____
NAME _____ DATE OF BIRTH _____
ADDRESS _____ HOME PHONE _____
CITY/ST/ZIP _____ CELL PHONE _____
OCCUPATION _____ WORK PHONE _____
E-MAIL ADDRESS _____
MARRIED SINGLE WIDOW(ER) DIVORCED NUMBER OF CHILDREN _____
SPOUSE _____ EMPLOYMENT _____ WORK # _____
Whom may we thank for referring you to us? _____

Personal Habits

Please circle any of the following you are taking:

Medications Drugs Vitamins/Supplements (Please specify these on the last page of the intake)
Consuming? Tobacco Alcohol Coffee

Present Health Condition

Height _____ Weight _____ Have you experienced any significant weight change in the past three months? Yes No.
If yes, please describe change _____

Please list your symptoms below in order of importance and give date symptoms began.

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____

Is this condition due to an auto accident? Yes / No. If yes, list date of accident . _____
Who was at fault? _____
Is this condition a direct result from an injury which occurred at work? Yes No. If yes, date and time of injury _____
_____ Did you report this injury to your employer? Yes No.

In case of an emergency who should be contact? Name _____
Daytime phone #_____ Relationship?_____

**I understand and agree that all services are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend/terminate my care, all fees for services will be immediately due. Payment is expected at time of visit. Please respect the 24hr cancellation policy as a $30 no-show fee will be charged to the account which is not billable to insurance.*

Patient/Guardian Signature:_____ Date_____
If under 18, parental consent required: I (please print) _____ give Life Springs Chiropractic permission to treat my son/daughter with chiropractic care.
Parent/Guardian signature: _____

Life Springs Chiropractic is in-network with a many insurance companies and will file your insurance claim as necessary. Please give your ID and insurance card to the front desk or the Dr so we can do a verification of benefits for you.

Please complete Health History on back of this page

Health History

Have you ever had the same or similar symptoms? Yes No. If yes, when? _____
Have you had treatment by another doctor for these symptoms? Yes No.
If yes, name of doctor _____
Is there any family history of this type of pain? Yes No.
Have you had any previous Chiropractic care? Yes No.
Have you ever been hospitalized? Yes No. If yes, when and why? _____
Have you ever broken any bones? Yes No. If yes, when and what? _____
Have you noticed any recent changes in bowel or bladder habits? Yes No. If yes, please describe _____
_____.

Please check below if you or a member of your family has ever been diagnosed with or suffered from:

You	Family	Relationship (Father, Mother, Sister, etc ...)	
_____			1. Cancer
_____			2. Diabetes
_____			3. Thyroid Disease
_____			4. Hypertension (High Blood Pressure)
_____			5. Hypercholesterolemia (High Cholesterol)
_____			6. Atherosclerosis (Heart Disease)
_____			7. Kidney Disease
_____			8. Osteoporosis
_____			9. Neuromuscular Disease (i.e. Parkinson's, Multiple Sclerosis)
_____			10. Rheumatoid arthritis
_____			11. Allergies/Asthma
_____			12. Scoliosis
_____			13. Low back pain/or surgery
_____			14. Headache/Migraine
_____			15. Gastrointestinal Problem (Gallbladder, Ulcers, Diverticulitis)
_____			16. Liver Disease (Hepatitis, Cirrhosis)
_____			17. Other

Please notify the Doctor if you suffer from any medical condition not listed on this form.

Female Health History

Date of last menstrual cycle_____. Was it regular or irregular? _____
Is there any possibility that you are pregnant? Yes No Maybe
Are you using some form of birth control pill? Yes No. If yes, what kind _____
Do you have an annual gynecological exam? Yes No.
If over 40, do you have a regular mammogram? Yes No.

Male Health History

Do you have a regular prostate exam? Yes No.
Have you had a recent Prostate Specific Antigen test? Yes No.

Primary Care Provider

Do you have a primary care physician? Yes No
Doctor's name: _____ Phone #: _____
Practice name (if applicable):_____ Location (City/State is fine) #: _____

If you would like us to send any records from your visits at Life Springs Chiropractic to your primary physician, please ask for a release of records form at the front desk, and be sure to provide us with the doctor's name and fax number.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy for our privacy notices.

I authorized Life Springs Chiropractic to contact me with information related to my personal health needs and interests. The physician's office may use any phone number or email in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my home answering machine or voice mail service. I may be contacted about the following:

- Appointment reminders or schedule changes.
- Information about alternative treatments, presentations or events.
- Other health related information that may be of interest to me.

To contact me, I authorize Life Springs Chiropractic to use and disclose the following information:

- My Name, Address, Email and Phone Numbers.
- The Name of my Physician and the Clinic where I was treated.

NOTE: NO DIAGNOSIS OR TREATMENT INFORMATION WILL BE USED OR DISCLOSED.

Patient Name: _____ Date of Birth: _____
(PLEASE PRINT)

Patient Address: _____ Phone: _____
(STREET)

_____ Email: _____
(CITY, STATE, ZIP)

Life Springs Chiropractic fully supports the protection of health information. Only the physician and office staff will use this information to contact you. While we retain the standard rights of disclosure as provided under HIPAA, this authorization allows us to access only the above authorized information for contact purposes. This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time or request to receive a copy of the protected health information to be used by writing to Life Springs Chiropractic - 1501 15th St NW Suite 102, Auburn, WA 98001. In this case, every effort will be made to discontinue future communications.

_____ _____
Signature (PATIENT OR PERSON AUTHORIZED) Date

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:

"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above:

Patient's Signature _____ Date _____

LIFE SPRINGS CHIROPRACTIC

Patient Symptom Survey

PATIENT'S NAME _____ ***DOB*** ____/____/____

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time…

Primary Complaints

090 ☐ General Good Health
091 ☐ Desires Nutritional & Metabolic Analysis
001 ☐ Skin Disorder L25.9
002 ☐ Acne L70.8
003 ☐ Psoriasis L40.8
004 ☐ Urticaria (Hives) L50.9
005 ☐ ADD/ADHD F90.1/F90.9
006 ☐ Allergies, Unspecified J30.9
007 ☐ Allergic Rhinitis from food J30.5
008 ☐ Sinusitis J01.90
009 ☐ Alzheimer's G30.9
010 ☐ Poor Concentration/Memory F07.8
011 ☐ Parkinson's Disease G20
012 ☐ Anemia D64.9
013 ☐ Arthritic Disorder M12.9
014 ☐ Osteoporosis M81.0
015 ☐ Asthma J45.909
016 ☐ Emphysema J43.9
017 ☐ Cancer
- 018 ☐ Breast C50.919female C50.929male
- 019 ☐ Prostate C61
- 020 ☐ Lung C34.90
- 021 ☐ Colon and Rectal C18.9
- 022 ☐ Skin C44.90
- 023 ☐ Leukemia w/o remission C95.90 Leukemia w/ remission C95.91
- 024 ☐ Lymphoma, malignant C85.89
- 025 ☐ Brain Tumor, malignant C71.9

027 ☐ Anxiety Disorder F41.9
028 ☐ Autism F84.0
033 ☐ Edema R60.9
034 ☐ Eczema L25.9
035 ☐ Chronic Fatigue R53.82
036 ☐ Circulatory Disorder I99.9
037 ☐ Heart Disease I51.9
038 ☐ High Cholesterol E78.0
039 ☐ High Blood Pressure I10
040 ☐ Low Blood Pressure I95.9
041 ☐ Tachycardia (High Heart Rate) R00.0
042 ☐ Numbness R20.9
043 ☐ Constipation K59.00
044 ☐ Indigestion K30
045 ☐ Ulcerative Colitis K51.90
046 ☐ Depression F32.9
047 ☐ Diabetes Mellitus E11.9
030 ☐ Diabetes Type I E10.9
031 ☐ Diabetes Type II E11.65
029 ☐ Hyperglycemia [high blood sugar] R73.09
048 ☐ Hypoglycemia [low blood sugar] E16.2
049 ☐ Dizziness/Balance Problem R42
050 ☐ Ear Infection H65.90
051 ☐ Epstein Barr B27.90
052 ☐ Eye Problems H57.13
053 ☐ Cataracts H26.9
054 ☐ Glaucoma H40.9
055 ☐ Macular Degeneration H35.30
056 ☐ Fever R50.9
057 ☐ Fibromyalgia M79.7
058 ☐ Gallbladder Disorder K82.9
059 ☐ Gout M10.9
060 ☐ Headaches R51
061 ☐ Hearing Loss H91.90
062 ☐ Infertility, male N46.9
064 ☐ Liver Disease K76.9
- 065 ☐ Hepatitis K71.6
- 066 ☐ Hepatitis B B16.9
- 067 ☐ Hepatitis C B17.10

068 ☐ Kidney Disorder N28.9 or Bladder Disorder N32.9
063 ☐ Prostate Disorder N42.9
069 ☐ Hyperthyroidism E05.90
070 ☐ Hypothyroidism E03.9
071 ☐ Systemic Lupus M32.10
072 ☐ Infertility, female M97.9
073 ☐ Interstitial Cystitis N30.11
074 ☐ Irregular Menstrual Cycle N92.6
075 ☐ Menopausal Symptoms N95.1
076 ☐ Hot Flashes N95.1
077 ☐ Mental Disorder F99
078 ☐ Insomnia G47.00
079 ☐ Mouth/Throat/Tongue
080 ☐ Canker Sores K12.0
081 ☐ Overweight E66.3
082 ☐ Underweight R63.6
083 ☐ Sexual Disorder F66
084 ☐ Spinal Problems M53.9
085 ☐ Obesity E66.9
086 ☐ GERD K21.9
087 ☐ HIV B20
088 ☐ Crohn's Disease K50.90
089 ☐ Irritable Bowel Syndrome K58.9
092 ☐ Normal Pregnancy Z33.1
**only applicable if *currently* pregnant
093 ☐ Shingles B02.9
140 ☐ Migraines G43.909
141 ☐ Rheumatoid Arthritis M06.9
142 ☐ Non-Systemic Lupus L93.0
143 ☐ Multiple Sclerosis G35
144 ☐ ALS (Lou Gehrig's) G12.21
145 ☐ Polymyalgia Rheumatica M35.3
146 ☐ Scleroderma M34.9
171 ☐ Goiter E04.9
178 ☐ Raynaud's Syndrome I73.00
179 ☐ Hemochromatosis E83.119
180 ☐ Thalassemia D56.8
181 ☐ Brain aneurysm I61.9

If necessary, please state your most significant concern above…

Medications

Please list all drugs you are <u>currently</u> taking on a <u>daily basis</u>.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Please list all drugs taken <u>within the last year and/or you take as needed</u> including over the counter drugs, antibiotics, aspirin, inhalers, etc.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

☐ Dairy	☐Gluten	☐ Ragweed	☐ Sulfa drugs
☐ Eggs	☐ Mold	☐ Shellfish	☐ Tree nuts
☐ Garlic	☐ Peanut	☐ Soy	☐ Wheat

☐ Other _____

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

VITAMIN	***BRAND***	***DOSAGE***