Lifetime Family Health Center PLLC

Patient Registration

Patient Contact

Title: Mr./Mrs./Ms./Dr._____ Date_____

Last Name_____ First Name_____ M.I_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Mobile Phone_____

Work Phone_____ E-Mail_____

Patient Personal

Age_____ Date of Birth_____ Gender: Male Female

Social Security #_____ Drivers License #/ State_____

Employer Name_____ Occupation_____

Marital Status: Single Married Widowed Separated Divorced

Spouse Name_____ Employer_____ Phone_____

Children (names, ages)_____

Emergency Contact

Name_____ Relationship_____

Home Phone_____ Mobile Phone_____ Work Phone_____

Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend or Family Member Name_____

□Yellow Pages □Website □Presentation □Sign □Newspaper □Other_____

Have you ever received chiropractic care? Yes No

If yes, When and Where?_____

Do you have health insurance? Yes No If yes, company?_____

Who is your Health Insurance through?_____ Their Date of Birth_____

Who is your:

Primary Care Physician_____ Phone Number_____ Last Visit_____

Massage Therapist_____ Phone Number_____ Last Visit_____

Patient Case History

I. Health Complaints

□ I have no health complaints, I am interested in prevention and health wellness (skip to section II)

What is your **primary** complaint?_____

How long have you been experiencing the primary complaint?_____

How does the primary complaint feel? □ dull □ sharp □ numb □tingling □burning □spasm □other_____

How often do you experience the primary complaint? □ constantly □ daily □ weekly □ monthly □ yearly

What makes your primary complaint better?_____ worse?_____

Have you missed any work or school because of your primary complaint? □ yes □ no

How does your primary complaint affect you at home/work/school?_____

Have you had any prior treatment for your primary complaint?_____

What do you believe is causing your primary complaint?_____

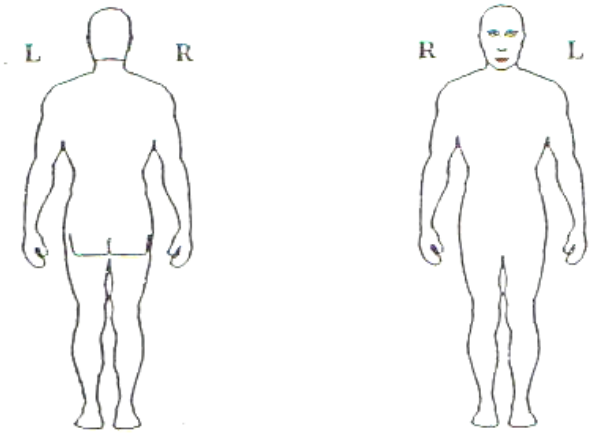
List other health complaints on the following lines:

2_____ 3_____

4_____ 5_____

6_____ 7_____

Please mark the areas of all of your complaints on the diagrams to the right.



Please rate the average intensity of your pain below.

(No Pain) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (Severe Pain)

II. Health History

Are you pregnant? Yes No If yes, how many weeks? _____

How often do you use tobacco? ☐ never ☐ daily ☐ weekly ☐ monthly

How many servings of alcohol do you drink each week? □ 0 □ 1-2 □ 3-5 □ 6-9 □ 10-20 □ >20

How many servings of coffee do you drink each week? □ 0 □ 1-2 □ 3-5 □ 6-9 □ 10-20 □ >20

How many servings of soda do you drink each week? □ 0 □ 1-2 □ 3-5 □ 6-9 □ 10-20 □ >20

How many glasses of water do you drink each day? □ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9+

How many times do you eat per day? □ 1 □ 2 □ 3 □ 4 □ >5

How many servings of fruits and vegetables do you eat per day? □ 0 □ 1-2 □ 3-5 □ 6-9 □ >9

How often do you exercise? □ daily □ 5x/week □ 4x/week □ 3x/week □ 2x/week □ 1x/week □ I don't exercise

Please mark any of the following that apply to you?

□ Headaches	□ Wrist/Hand Pain	□ Hepatitis	□ Low Back Pain
□ Seizures	□ Upper Back	□ Gallbladder Removed	□ Hip Pain
□ Multiple Sclerosis	□ Mid Back Pain	□ Diabetes	□ Knee Pain
□ Visual Problems	□ Asthma	□ Anemia	□ Ankle/Foot Pain
□ Allergies/Sinus	□ Chest Pain	□ Irritable Bowel Syndrome	□ Cancer
□ Ringing In Ears	□ High Cholesterol	□ Digestive Problems	□ Arthritis
□ Neck Pain	□ High Blood Pressure	□ Constipation	□ Autoimmune Disease

□ Hypothyroidism □ Acid Reflux/Indigestion □ Hemorrhoids □ Fibromyalgia

□ Shoulder Pain □ Muscle Spasms/Cramps □ Menstrual Issues □ Weight (loss or gain)

□ Elbow Pain □ Ulcers □ Urinary Difficulties □ Other: _____

III. Hospitalization, Surgeries and Injuries

Do you have a pacemaker? ☐ yes ☐ no

Do you have any other implantable medical device in your body? ☐ yes ☐ no

Please list any hospitalizations, surgeries or injuries that you have had (if none, write NONE):

Date Description

1 _____

2 _____

3 _____

4 _____

IV. Medications and Supplements

Please list any supplements and/or medications (RX and OTC) you are currently taking and why (if none, write NONE):

1_____ 4_____

2_____ 5_____

3_____ 6_____

V. Family History

Have any of your blood relatives had any of the following conditions? If yes, please list who (if none, write NONE).

Heart Disease _____ Stroke_____

Cancer _____Arthritis _____

Diabetes _____Auto-Immune Disease _____

What types of care are you seeking? (mark all that apply)

☐ Injury prevention ☐ Nutritional and supplement counseling ☐ Health education classes☐ Wellness

☐ Balance and coordination training ☐ Spinal and body alignment ☐ Treatment for pain ☐ Other_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that this office uses a text reminder system and I consent to receiving text messages that may include promotional offers as well as appointment reminders.

I hereby authorize the Doctor to examine and recommend treatment for my condition as he or she deems appropriate.

Patient's Signature _____ Date _____

Guardian Consent to Treat a Minor_____ Date_____