maxliving
HEALTH CENTER

Application for Care at Life Essentials Chiropractic

Today's Date:_____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date:____-____-____ Age: _____ ☐Male ☐Female ☐Other

Address:_____City:_____State:_____Zip:_____

E-mail Address: _____ Home Phone: _____ Mobile Phone:_____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐Yes ☐No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name_____Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact:_____Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily:_____Third:_____Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by **circling the number:**

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin?_____When is the problem at its worst? ☐AM ☐PM ☐mid-day ☐late PM

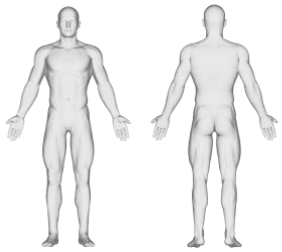
How long does it last? ☐ It is constant **OR** ☐I experience it on and off during the day **OR** ☐It comes and goes throughout the week

How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes If yes, when: _____ by whom? _____

How long were you under care:_____ What were the results? _____

Name of Previous Chiropractor: _____ ☐**N/A**



***PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms:
R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/ Stabbing **T**= Tingling

What relieves your symptoms? _____
What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ☐ Yes, ☐No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐Yes **If yes** how many times? _____

Other forms of treatment tried: ☐ No ☐ Yes If yes, please state what type of treatment:_____,
and who provided it:_____How long ago?_____What were the results? ☐Favorable
☐Unfavorable Please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the Past, **C** for Currently have or **N** for Never have had:

___ Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability___Cancer
___ Heart Attack ___Osteo Arthritis ___Diabetes ___Cerebral Vascular ___Other serious conditions:

PLEASE Identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

SOCIAL HISTORY

1. Smoking: ☐cigars ☐pipe ☐cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐No ☐Yes

If yes whom: ☐grandmother ☐grandfather ☐mother ☐father ☐sister(s) ☐brother(s) ☐son(s) ☐daughter(s)

Have they ever been treated for their condition? ☐No ☐Yes ☐I don't know

2. Any other hereditary conditions the doctor should be aware of> ☐No ☐Yes: _____

I hereby authorize payment to be made directly to this office for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to this office for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature Date Completed

_____ _____ - _____ - _____

Doctor's Signature Date Form Reviewed

Patient's Name: _____ HR#: _____ ___/___/___

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Patient Name_____ File#/HRN _____ Date_____

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____
What speed was the collision? _____
Type of impact: Front Impact / Side Impact / Rear Impact
Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____
Please describe the manner of the injury _____
Was treatment received? Please describe _____
Does your job require you remain in long term stressful postures?_____
(i.e. all day sitting, repeated lifting, long term computer use)

Spinal traumas in the past? _____
Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field_____
Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident_____
Work around the house – lifting, bending, woke up with stiff neck, "back went out"

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? (O Y/ O N) Values? _____

Have you tested with high blood pressure? (O Y/ O N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (O Y/ O N)

Do you eat breakfast daily from Monday to Friday? (O Y/ O N)_____

How many days per week do you skip one meal? O (0) O (1) O (2) O (3) O (4+)

How many fast food, refined foods, or prepared meals do you eat per week? O (0) O (1-3) O (4-6) O (7+)

How many servings of fruit do you have on a given day? O (0-1) O (2-3) O (4+)

How many servings of vegetables do you have on a given day? O (0-1) O (2-3) O (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

O Diet Soda O Coffee O Juice O Milk O Soda O Alcohol

Please list any supplements you take regularly:

_____
_____
_____

INITIAL FITNESS PROFILE

How many times per week do you exercise?

Cardiovascular____Hours____Days/Wk Weight Training____Hours____Days/Wk

Low Impact (Yoga, etc.)____Hours____Days/Wk

What is your target weight?_____What is your current weight? _____

How willing are you to change any of these things to reach your health goals? (Scale of 1-10) _____

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? (O Y/ O N)

Have you ever noticed mold growing in your home or your place of work? (O Y/ O N)

Does your home, work, school, or car have a damp or mildew smell? (O Y/ O N)

Have you received a full standard profile of vaccinations? (O Y/ O N)

Do you receive yearly flu shots? (O Y/ O N) How many flu shots have you received? _____(estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (O Y/ O N)

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (O Y/ O N)

INITIAL STRESS PROFILE

Do you get an average of 8 hours of sleep per night? (O Y/ O N)

Do you average less than 7 hours of sleep per night? (O Y/ O N)

Do you ever take pills to go to sleep or relax? (O Y/ O N)

Do you often feel short on time and procrastinate on projects? (O Y/ O N)

Do you experience feelings of anxiety about completing tasks? (O Y/ O N)

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? (O Y/ O N)

Do you rely more on your memory than a planner and action list to get things done? (O Y/ O N)

Do you take time to pray, meditate, or visualize on a regular basis? (O Y / O N)

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Activities of Daily Living/Symptoms/Medications

Patient Name: _____ Date: _____ File#_____

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Please mark P for in the Past, C for Currently have and N for Never

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Heartburn
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Digestive Problems	___ Digestive Problems
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Colon Trouble	___ High Blood Pressure
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Menopausal Problems	___ Asthma
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menstrual Problem	___ Difficulty Breathing
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ PMS	___ Lung Problems
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ Bed Wetting	___ Kidney Trouble
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Learning Disability	___ Gall Bladder Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling arms, hands, fingers		___ADD/ADHD	___Trouble Sleeping	___Hepatitis (A, B, C)
___ Impotence/Sexual Dysfunction		___Allergies	___Ulcers	

List Prescription & Non-Prescription drugs you take:_____

_____

_____

FOR OFFICE USE ONLY
I have reviewed the above ADL & ROS Form with the above named patient:

_____ _____
Doctor Signature Date

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at _____ Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ Witness Initials

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on____/____/____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ Witness Initials

Patient or Authorized person's Signature Date