Patient Intake

**Please do your best to fill out everything on this intake form. It is important that we understand past and current stressors that may have affected and could possibly continue to affect your overall health. It is important for us to know the following information, even if you feel it does not apply to the reason you came in for care. Please know that we value your time and aim only to provide you the best care possible. Thank you for choosing LifeLogic Health Center!*

Date: ______________________ Referred By: ____________________________________

Please check the type of care desired:

_____ Temporary Relief _____ Stabilization _____ Family Health/ Prevention _____Doctor's Advice

Is this appointment related to an: ______ auto accident ______ injury

Full Name: ____ Preferred Name:________________________

Address: ____ City: ________________________

State:________ Zip:_____________ Social Security #: __________-_________-_____________ Sex: M / F

Phone: Home: (_______) _________-___________ Cell: (________) _________-___________

Date of Birth: ______/_______/___________ Age: _________ Email: ____

Height: ________ft _________in Weight: ______________lbs

Marital Status: ❏ Single ❏ In a Relationship ❏ Married / Life Partner

❏ Divorced ❏ Widowed Significant Other's Name: ______________________________________

Emergency Contact: _______________________________________ Phone: (_________) ___________-______________

Occupation: ________________________ Employer: _________________________ Length of Employment: __________

Do you enjoy your job? Y / N Explain: ____

Duties/ Habits: _____ sit more than 1 hour _____ carry equipment/tools on your body (i.e. utility belt)

_____ repetitively bend or twist _____ cradle the phone shoulder to ear (which side? L or R)

_____ repetitively type _____ drive on the job (car or other) _____ lift more than 10 lbs repetitively

Children? Y / N How many & age(s): ____

❏ Pregnant; # weeks:____________ ❏ Planning to become pregnant;

Approximately when: _____________________________________

Name: ______________________________

Have you ever received chiropractic care before? Y / N   If yes, please list names and dates below:

1.Name: ______________________________ Dates: ______________________

2.Name: ______________________________ Dates: ______________________

Have you been to a medical doctor in the past year? Y / N   If yes, please list names and reasons below:

1.Name: ______________________________ Reason: ______________________
for visit

2.Name: ______________________________ Reason: ______________________
for visit

3.Name: ______________________________ Reason: ______________________
for visit

Name: ______________________________

How would you rate your health? (Please circle one)

(Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Please list the top 5 things you would like to change about your health:

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

5. ______________________

List *ALL* medications you take (prescriptions and over-the-counter- use back of page if necessary)

Drug name:	Dosage:	How long have you taken this and for what condition?

List *ALL* nutritional supplements you take. (Use back of page if necessary)

Supplement name:	Dosage:	How long have you taken this and for what condition?

Name: ____

List *ALL* previous hospitalizations, surgeries (include oral, appendix, hysterectomy, etc.), fractures, accidents, illnesses. (Use back of page if necessary)

1. Issue____ When _________________ Hospitalized? Y / N

2. Issue____ When _________________ Hospitalized? Y / N

3. Issue____ When _________________ Hospitalized? Y / N

Past medical diagnosis / condition: (Use back page if necessary)

1. What: ______________________________ When: _____________ Diagnosed by: _________________________________

2. What: ______________________________ When: _____________ Diagnosed by: _________________________________

On average, how many times per year do you get sick? ______________ **How long does it last?**__________________

Do you get sick seasonally or during the same time each year? Y / N **When?**______________________________

Do you have allergies? Y / N **If yes, are they seasonal, pets, pollen, etc?** __________________________________

Do you have any known food allergies? Y / N **Please list:**____

____

Do you consume the following? (Please mark "N/A" if it does not apply)

Tobacco products (packs/day) ________ # of years? ________ Alcohol (drinks/day) ________ # of years? _____________

Coffee/Espresso (cups/day) _______ Reg or decaf? ___________ Soft drinks (#/day) _________ Reg or diet? ___________

Tea (cups/day) ________ Type (herbal, black, green, etc.) ____________________ Amount of water/day ____________ oz.

Do you use artificial sweeteners? Y / N If yes, please list: ____

Other drinks and amount/day (juice, milk, etc.) ____ Energy drinks? Y / N

Level of exercise (please circle) None Moderate : ________ days/week Strenuous : __________ days/week

Have you experienced any unexplained or rapid weight changes in the last six months? Y / N __________ lbs

Do you currently have or have you experienced ANY of the following within in the past 2 years? Put "P" for past and "N" for now.

_____ Weight changes
_____ Sinus problems
_____ Allergies
_____ Cold hands
_____ Stroke
_____ Cancer
_____ High blood pressure
_____ Fatigue
_____ Diabetes (Type:_______)
_____ Changes in bowel/bladder habits

_____ Frequent infections
_____ Heart Disease
_____ Asthma
_____ Cold feet
_____ Nervous disorder
_____ Menstrual problems/ pain
_____ Low blood pressure
_____ Stress difficulty
_____ Arthritis (OA or RA?)
_____ Concussion /Head injury

___ Respiratory disease
___ Hardening of arteries
___ Numbness/Tingling
___ High cholesterol
___ Digestive problems
___ HIV or AIDS
___ Headaches (____x/______)
___ Surgery
___ Jaw trouble/TMJ issues
___ Neurological issues

List your #1 health concern: ____

Rate the severity of issue: (mild) 1 2 3 4 5 6 7 8 9 10 (extreme)

When did this first begin? __________ **Date of most recent flare-up**: ____________________

Have you seen anyone for this issue? Y / N **Whom?** ______________ **When?** __________

What was the treatment or advice? ____

What was the result? Did it seem to work? ______________________________________

What aggravates this condition? ____

What makes it better? ____

Is it worse at certain times of the day, week or month? Y / N **When?** ____________________

Is it getting progressively worse? Y / N **Do you get flare-ups?** Y / N **How often?** ____________

Have you had this or something similar in the past? Y / N **When?**____________________

What treatment did you receive at that time? ______________________________________

Please check any of the following activities that the above condition *interferes* with:
❑ Personal Care ❑ Lifting ❑ Bending ❑ Pushing ❑ Pulling ❑ Walking ❑ Reading ❑ Driving ❑ Standing
❑ Sleeping ❑ Hobbies ❑ Sports ❑ Work ❑ Concentrating ❑ Family/Home Responsibilities ❑ Eating/Breathing
❑ Socializing ❑ Going to the Bathroom ❑ Sexual Interactions ❑ Having Children ❑ School ❑ Being Healthy

Your answers to the following questions will allow us to help you to better participate in a program of care specifically focused on your nervous system, your wellness, and your overall health.

Which of the following choices best describes your level of motivation for creating changes in your health?
- a.) I am uncomfortable/unwilling to change my current routines and lifestyle.
- b.) I would be willing to make minor changes that fit into my current lifestyle.
- c.) I am willing to make changes in my routines and habits, and am willing to step out of my comfort zone.
- d.) I am willing to do **anything** necessary to create positive changes in my health.

Which of the following choices best describes your willingness to alter your current diet and food choices?
- a.) I am uncomfortable/unwilling to change my current diet and food choices.
- b.) I would be willing to make minor changes that fit into my current lifestyle.
- c.) I am willing to make changes in my diet and food choices, and am willing to step out of my comfort zone.
- d.) I am willing to do **anything** necessary to create positive changes in my health.

Which of the following choices best describes your level of motivation for becoming educated, doing work at home, and being responsible for your health outcomes?
- a.) I am uncomfortable/unwilling to change my current routines and lifestyle and am unmotivated to learn.
- b.) I would be willing to make minor changes that fit into my current lifestyle.
- c.) I am willing to make changes in my routines and habits, and am willing to step out of my comfort zone.
- d.) I am willing to do **anything** necessary to create positive changes in my health.

Is there anything else which may help us understand you, your history, or your needs which have not been covered in this intake? Please explain: ____

____

____

**Remember, health is a process. Past and present choices affect this process. Thank you for taking the time to provide us with the information we need to best help you achieve your health goals. Congratulations on taking an active step toward health and thank you for giving us the opportunity to participate in this process!*

Legal Agreements

I agree that a photocopy or facsimile of any document I sign for LifeLogic Health Center, LLC will be deemed as valid and binding on all parties involved as if the photocopy was the original document I sign.

Signature: ____ Date: _____________________________________

With my signature, I verify that I have gone to the U.S. Department of Health & Human Services website at **http://www.hhs.gov/ocr/privacy/** to review my health information privacy rights. I understand that I can ask the doctors in the office if I have any questions regarding my HIPAA rights.

Signature: ____ Date: _____________________________________

Accuracy of Information

Females Only:

I, ____, to the best of my knowledge confirm that I am not pregnant, and waive all responsibility of the Doctor(s) for any complications if I am pregnant. (If you are, or might be pregnant, please inform the doctor(s) so they can modify your care plan accordingly.)

All Patients:

With my signature, I attest that all of the information on this form is accurate and that I am over the age of 18 years. If this information is pertaining to a patient under the age of 18, I am a legal guardian or parent of the aforementioned individual.

Signature: ____ Date: _____________________________________