

Lifetime Health and Wellness

"Pain Relief Today.....Health for a Lifetime"



New Patient Entrance Form

How did you hear about us ?

Friend/Family: _____ Website
 Ad: _____ Other: _____

Please Print

Patient Information =====

Today's Date: _____ Sex: Female Male

Name (First, MI, Last) _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Birthdate _____ Age _____

Are You: Minor Married Divorced Widowed Single Separated

Home Phone _____ Cell Phone _____ Work Phone _____

Which phone do you prefer to receive calls? Home Cell Work

Can we leave a message on your phone? Yes No

Can we text you messages on your cell phone? Yes No

Race/Ethnicity _____ Preferred Language _____

Email Address _____

May we contact you or send information via email ? Yes No

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

=====

Spouse's/Parent's Name _____

Emergency Contact Name (First, Last) _____

Emergency Contact Phone Number _____ Relationship _____

Lifetime Health and Wellness

"Pain Relief Today.....Health for a Lifetime"



Patient Name (printed) _____ Birthdate _____

WHAT PROBLEM BRINGS YOU TO SEE US TODAY? _____

WHEN DID THIS PROBLEM START? _____

Did it come on SUDDENLY BUILT UP OVER SEVERAL DAYS GRADUALLY WORSE OVER A LONG TIME

Due to an injury? No Yes At Work Motor Vehicle Accident Other : _____

Describe the Cause: _____

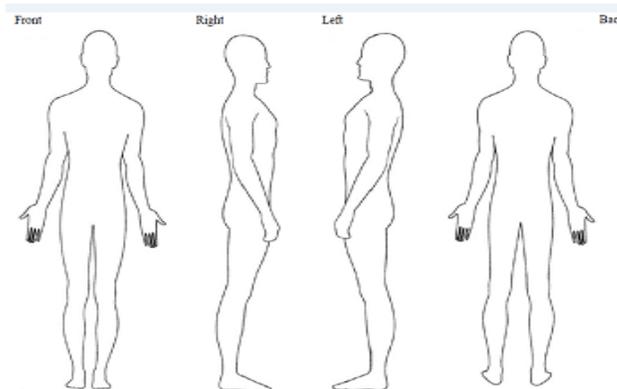
ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.

Circle the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time and how frequent.

AREA 1 pain is (1-10) _____ Constant or Intermittent
At _____ % of my day

AREA 2 pain is (1-10) _____ Constant or Intermittent
At _____ % of my day

AREA 3 pain is (1-10) _____ Constant or Intermittent
At _____ % of my day



Please help us understand your pain: Circle the words for each area that best describes your pain and activity during you day.

Area 1 is: Worse in AM At Night After Exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 2 is: Worse in AM At Night After Exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 3 is: Worse in AM At Night After Exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

I have difficulty with: Walking Sitting Standing Driving a car Sleeping My daily routine Bladder Control Depression

I currently am: Ambulatory without assistance Need to use: Support Brace _____ Walker Cane Crutches Wheelchair

Please help us better understand **your personal circumstances** and assist us in providing you customized treatment and care.

I Am Working _ Full Time _ Part Time _ Unemployed _ Retired _ Homemaker _ Full Time Student

Now: _ On sick leave _ On Temp disability _ On Full Disability My last day worked was : _____

Occupation : _____

Age _____ _Single / never married _ Married _ Separated _ Filing for Divorce _ Divorced

Please feel free to discuss with us any situation in your personal relationships that may affect your recovery.

I Now _ never smoker _ Smoke _ Packs per day Stopped _____ _ Use Alcohol Type/Amount _____

_ Consume Caffeine: Type/Amount _____ _ Use recreational drugs cannabis _____

I am now or have in the past been: _ Addicted to _ drugs _ alcohol _ Treated for _ alcohol or _ drug addiction

Provider Initials _____

Patient Name (printed) _____ Birthdate _____

Past Procedures:

If you previously had any of the following procedures, please list the date and place they were performed.		
PROCEDURE	DATE(S)	PLACE PERFORMED
X-Rays		
C.T. / MRI		
Ultrasound		
E.M.G.		
Cardiogram		
Last Physical Exam		
Are you now under care with another physician ? <input type="checkbox"/> No <input type="checkbox"/> Yes For ?		

PATIENT MEDICAL HISTORY:

<i>Have you had or have?</i>	<i>No</i>	<i>Past</i>	<i>Now</i>		<i>No</i>	<i>Past</i>	<i>Now</i>		<i>No</i>	<i>Past</i>	<i>Now</i>
Aids/HIV				Ear Infections				Loss of Smell			
Alcohol / Drug Abuse				Emphysema				Loss of Taste			
Allergy Shots				Fainting				Menstrual Disorders			
Anemia				Falls / Balance disorders				Mid/Low Back Pain			
Arthritis / Gout				Fatigue				Migraine Headaches			
Asthma/Bronchitis				Fever				Miscarriage			
Bleeding Disorders				Foot /Ankle pain				Multiple Sclerosis			
B/P High / Low				Fractures				Neck pain/spasms			
Breast Lump				Gall Stones				Nervousness			
Buzzing/Ringing in Ears				Groin or Rectal Pain				Neuropathy			
Cancer ::				Headaches				Numbness in Fingers			
Carpal Tunnel Syndrome				Hearing Deficits				Numbness in Toes			
Cataracts				Heart Burn				Obesity			
Chemical Dependency				Heart Disease- Attack				Osteoporosis			
Chest Pain - SOB				Hepatitis				Pacemaker			
Chronic Fatigue				Hernia				Pancreatitis			
Cognitive Deficits				Herniated Disc				Parkinson's			
Cold Feet				High Cholesterol				Pinched Nerve			
Cold Hands				Hip/Knee/Leg Pain				Pins/Needles in Arms			
Cold Sweats				HIV / AIDS				Pins & Needles in Legs			
Constipation				Hot Flashes				Polio			
COPD				Irregular heart beat				Pregnancy			
Depression/Anxiety				Irritability				Prostate Problems			
Diabetes				Jaw Pain				Psychiatric Care			
Diarrhea				Kidney Disease				Rheumatoid Arthritis			
Digestive Problems				Knee Pain/ Osteoarthritis				Sacroiliac Problems			
Dizziness				Loss of Balance				Seizures			

Provider Initials _____

Patient Name (printed) _____ Birthdate _____

PATIENT MEDICAL HISTORY: continued

<i>Have you had or have?</i>	<i>No</i>	<i>Past</i>	<i>Now</i>		<i>No</i>	<i>Past</i>	<i>Now</i>		<i>No</i>	<i>Past</i>	<i>Now</i>
Shortness of Breath				Stomach / Ulcer Pain				Tumors			
Shoulder/Elbow Pain				Stress				Ulcers			
Sinus Trouble				Stroke / CVA / TIA				Upset Stomach			
Skin Problems				Swallowing Difficulty				Urinary Problems			
Sleeping Problems				Tension				Visual Deficits			
Spinal disc problems				Thyroid Problems				Whooping Cough			
Stiff Neck				TMI				Other:			

Reviewed by Provider (Signature) _____

Date _____



Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability, if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Patient (Guardian) Signature _____

Date _____

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

Patient (Guardian) Signature _____

Date _____

Insurance Agreement

We are happy to be able to assist you with your insurance benefits that you have either purchased or been given through your employer. We will assist you by doing the billing for you, preparing the necessary forms, applying the contracted discounts and waiting for the insurance company payments for at least 60 days.

We would like you to understand that your insurance is a form of payment that is a purchased contract between you and the insurer. We have little control over what or if they will actually pay for the services that you receive. The determination that the carrier makes on what and how much will be paid on your behalf is based on a set of complicated guidelines. As such we will do our best to assist you in receiving whatever payment they will make on your behalf. We cannot guarantee or be held responsible for any amounts not covered or not paid for by their determinations.

If we need to speak to your insurance carrier on your behalf to help resolve claim issues they require a signed Appointment of Representative release which we may ask you to sign on your first visit and keep on file.

The care that we will provide to you is always based on what the Providers at Lifetime Health and Wellness Center believe are safe, necessary and most beneficial for the treatment of the condition you present with. We will always provide the best care at the most reasonable cost and with your consent, agreement and participation.

For the purposes of this agreement and understanding we are informing you that you are responsible for all the services rendered to you and that any services that are determined by a third party (insurance company or others) to not be payable under your policy will be due and payable personally by you.

Patient (Guardian) Signature _____

Date _____

Authorization & Financial Agreement

Authorization -----

I certify that I have read and understood the information on the Patient Intake Form. The statements on the Patient Intake Form are accurate to the best of my recollection. I understand that providing incorrect information can be dangerous to my health.

I authorize the office to examine me for further evaluation. I authorize and request my insurance company to pay directly to Lifetime Health and Wellness Center, insurance benefits otherwise payable to me. This is a direct assignment of my rights and benefits under this policy. I understand that my insurance carrier may pay less than the actual bill for services. I agree to pay, any balance of said professional service charges over and above this insurance payment. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient (Guardian) Signature _____ **Date** _____

Financial Agreement -----

In exchange for the caring service that Lifetime Health and Wellness Center provides me, I will do my part and agree to personally pay for all of the charges rendered to me.

In an effort to help me with this obligation, Lifetime Health and Wellness Center may extend the privilege of helping me to use my health and or accident insurance as a funding source (see Insurance Agreement) for payment of costs associated with my care. I know that health and accident insurance policies are an agreement between my insurance carrier and myself, so I will authorize and request them to pay this office directly, and I also give this office power of attorney to endorse checks made out to me from my insurance company, to be credited directly toward the balance on my account. I realize that my insurance may not cover or pay for all or some of the services I may receive. I therefore, take full responsibility for payment of any of the unpaid balances in a timely manner.

In the unlikely event that my account become delinquent for non-payment, I agree to pay statement fee charges at the rate of 1 ½ % per month on the unpaid balances, and if I do not respond to Lifetime Health and Wellness Centers requests for payment and my account has to be referred out to a collection service, I understand that I will have to pay all collection agency and/or attorney fees associated with that referral.

Patient (Guardian) Signature _____ **Date** _____

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name _____ Date of Birth _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Lifetime Health and Wellness Center (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of the Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of this office to leave reminder messages on my answering system or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

Patient (Guardian) Signature _____ **Date** _____
