LifeWorks Chiropractic Clinic
Dr. Justin Thole, D.C.
Dr Kyle Reynolds DC

2032 Lowe St. #102 • Fort Collins, CO 80525 • www.lifeworks-chiropractic.com

Chiropractic Registration and History

Patient Information

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex: ☐ M ☐ F Age _____

Birth Date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Spouse's Birth Date _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Phone Numbers

Home Phone (_____) _____ Alt. Phone (_____) _____

Best time and place to reach you _____

Would you like to receive text reminders of your appointments? ☐ Yes ☐ No

Cell Phone (_____) _____ Who is your carrier? _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Alt. Phone (_____) _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth Date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian, or Personal Representative

_____ _____
Date Relationship to Patient

Accident Information

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

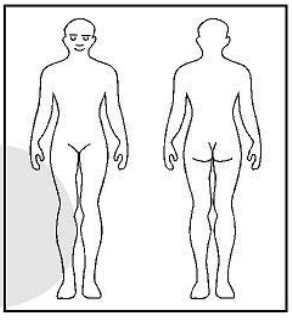
Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture to the right where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down

-OVER-

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Mark box "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____
Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	_____
Cataracts	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	
Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	

Please mark in each column which boxes best describe your activites:

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Are you pregnant? ☐Yes ☐No Due Date _____

Injuries/Surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____) _____

Pharmacy E-Mail _____

Allergies

_____

_____

_____

_____

_____

Vitamins/Herbs/Minerals

_____

_____

_____

_____

_____

Signature _____

If Minor, Parent or Guardian Signature _____

Health Questionnaire

SKIN, HAIR, NAILS

- ☐ Eczema
- ☐ Itchy skin
- ☐ Dry scalp
- ☐ Oily scalp
- ☐ Rough, scaly skin
- ☐ Dry skin
- ☐ Oily skin
- ☐ Psoriasis
- ☐ Yellow skin
- ☐ Bruise easily
- ☐ Paper thin nails
- ☐ Pale skin
- ☐ Nail biting
- ☐ Baldness

EYES

- ☐ Blurring of vision
- ☐ Double vision
- ☐ Eyes fatigue easily
- ☐ Excessive tearing
- ☐ Lack of tearing
- ☐ Light bothers eyes
- ☐ Excessive itching
- ☐ Pain in eyeball

EARS

- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Discharge from ears
- ☐ Vertigo
- ☐ Ringing in ears

NOSE, SINUS

- ☐ Unusual nasal discharge
- ☐ Nose bleeds
- ☐ Pressure over eyes
- ☐ Pressure under eyes
- ☐ Obstruction of nose
- ☐ Frequent colds
- ☐ Sinusitis
- ☐ Nasal allergies
- ☐ Loss of sense of smell
- ☐ Any trauma to nose

MOUTH AND THROAT

- ☐ Pain in mouth
- ☐ Pain in throat
- ☐ Bleeding in gums
- ☐ Cavities
- ☐ Abscessed teeth
- ☐ Dentures
- ☐ Difficulty swallowing
- ☐ Changes in voice

RESPIRATORY

- ☐ Shortness of breath
- ☐ Can't breathe while lying down
- ☐ Can't sleep while lying down
- ☐ Dry cough
- ☐ Productive cough
- ☐ Coughing up blood
- ☐ Wheezing

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Constant nibbling
- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ Can't eat some foods
- ☐ Nausea & vomiting
- ☐ Jaundice
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids

GENITOURINARY

Urination is

- ☐ Frequent
- ☐ Normal
- ☐ Infrequent

The amount is

- ☐ High
- ☐ Normal
- ☐ Low
- ☐ Waking at night to urinate
- ☐ Abnormal intense desire to urinate
- ☐ Difficulty starting to urinate
- ☐ Decreased output
- ☐ Pain on urination
- ☐ Dribbling
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Lack of bladder control
- ☐ Abdominal pain

VENEREAL DISEASE

- ☐ AIDS
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Other

SOCIAL HISTORY

- ☐ Smoking
- ☐ Other tobacco use
- ☐ Alcohol use
- ☐ Drink coffee or tea

Diet is

- ☐ Balanced
- ☐ Not balanced

Rest is

- ☐ Sufficient
- ☐ Not sufficient

Recreation is

- ☐ Sufficient
- ☐ Not sufficient

My Family Stress is

- ☐ Severe
- ☐ Moderate
- ☐ Minimal
- ☐ None

How do you like your work?

- ☐ I like it very much
- ☐ It's ok
- ☐ I hate it

My job stress is

- ☐ Severe
- ☐ Moderate
- ☐ Minimal
- ☐ None
- ☐ Nervousness
- ☐ Irritability
- ☐ Fatigue
- ☐ Depression
- ☐ Generally feel run-down
- ☐ Crave sweets
- ☐ Crave salt

WOMEN ONLY

- ☐ Painful periods
- ☐ Spotting
- ☐ Vaginal discharge
- ☐ Premenstrual symptoms
- ☐ Irregular periods
- ☐ Lumps in breast

#of Pregnancies_____

#of Deliveries_____

CARDIOVASCULAR

- ☐ General swelling
- ☐ Swelling in legs
- ☐ Swelling in face
- ☐ Swelling around eyes
- ☐ Chest pain
- ☐ Pounding heart beat
- ☐ Heart "jumps"
- ☐ Rapid heart beat
- ☐ Blue or purple skin
- ☐ Blue or purple nail beds
- ☐ Fainting
- ☐ Hypertension

VERTEBROBASILAR

- ☐ Double vision
- ☐ Loss of coordination
- ☐ Irregular muscle movement
- ☐ Ringing in ears
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Hardening of the arteries
- ☐ Areas of muscle weakness
- ☐ Dizziness with nausea
- ☐ Dizziness without nausea
- ☐ Blurred vision
- ☐ Fainting spells
- ☐ Stroke
- ☐ Diabetes
- ☐ Pain over the heart
- ☐ Cold hands and/or feet
- ☐ Areas of numbness
- ☐ Arthritis of the neck
- ☐ Previous neck or head injury
- ☐ Loss of memory
- ☐ Inability to form words
- ☐ Periods of blindness in one eye
- ☐ Areas of abnormal sensations such as burning etc.
- ☐ Blood vessel disease (phiebitis etc.)
- ☐ Check if you smoke
- ☐ Check if any of your family members have had a stroke
- ☐ Check if you are taking birth control pills

MUSCULOSKELETAL SYSTEM

HEAD

- ☐ Unusually frequent headaches
- ☐ Unusually severe headaches
- ☐ Head feels heavy
- ☐ Vertigo
- ☐ Light headedness
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness

NECK

- ☐ Pain in neck
- ☐ Neck pain with movement
- ☐ Swelling in neck
- ☐ Stiff neck
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sound in neck
- ☐ Popping sound in neck
- ☐ Limited neck movement

SHOULDERS

- ☐ Pain in shoulders (L-R)
- ☐ Pain across shoulders
- ☐ Tension in shoulders
- ☐ Muscle spasms in shoulders
- ☐ Can't raise arm:
- ☐ Above shoulder level
- ☐ Over head

ARMS & HANDS

- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles:
- ☐ In arms
- ☐ In fingers
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Loss of grip strength

MID BACK

- ☐ Mid back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing pain
- ☐ Dull ache
- ☐ Pain front to back
- ☐ Pain over kidney area
- ☐ Muscle spasms in mid back

LOW BACK

- ☐ Low back pain
- ☐ Low back feels out of place
- ☐ Muscles spasms in low back

HIPS, LEGS, & FEET

- ☐ Pain in buttocks
- ☐ Pain down leg
- ☐ Knee pain
- ☐ Leg cramps
- ☐ Pins and needles in legs
- ☐ Numbness in legs
- ☐ Numbness in toes
- ☐ Cold feet
- ☐ Swollen ankles
- ☐ Swollen feet

LifeWorks Chiropractic
DR. JUSTIN THOLE, D.C.

Dr Kyle Reynolds DC

2032 Lowe Street, Suite 102, Fort Collins, CO 80525 Tel: (970)377-1810 Fax: (970)377-1815 lifeworks-chiropractic.com

OFFICE POLICIES

(Updated as of 01.01.19)

CHECKING IN:

- **Sign-In on the IPAD and update your symptoms** thoroughly each and every appointment.
- Complete any paperwork when your appointment requires progress exams, insurance pre-authorization, release of medical records, progress evaluation, etc.

LATE ARRIVALS:

- Front Desk will call after you are 10 minutes late to re-schedule. We may still be able to see you but no guarantee. Please inquire and we will always squeeze you in if possible, but it may mean waiting for the next available opening and/or only receiving an adjustment.

CHECKING OUT AT FRONT DESK:

- **Schedule or verify your next appointment** or preferably recurring group of appointments.
- **Make your payment each appointment** unless you have set-up a payment plan providing your debit/credit card to be ran monthly or have pre-paid your care plan in full.

SCHEDULING:

- **Doctors recommend and request that you always book a next appointment,** even if it's tentative. You can always re-schedule if necessary. This ensures that your care frequency is maintained and that your results will not be delayed or negatively impacted.
- Book out as far as your schedule will allow per phase of treatment. This will afford you to reserve time slots you want and ensure you stay on track with your prescribed care plan.
- If you are unable to keep an appointment - call, email or text right away to reschedule.
- Provide a reason if you have no other option but to cancel your appointment.
- Make sure you are set-up on our appointment reminder system via text or email.
- **We reserve the right to charge for excessive missed appointments** and those cancelled without 24-hour notice. Front Desk will provide 3 warnings before a $25 charge is applied.

INSURANCE:

- Until the Front Desk is able to verify your chiropractic benefits, you will be charged on a cash-basis. This is usually achievable on the 1st appointment but not always.
- Make certain your insurance is applying your benefit or paying their portion as contracted. If a claim is denied, we will attempt to re-bill. If denied a 2nd time, the patient is financially responsible and will need to contact their insurance directly to resolve any discrepancies.

COMMUNICATION:

- **Self-Advocate and track your care plan.** It is a team effort though, so ask the Front Desk about your care plan and/or payment plan status anytime upon checking in or out.
- Update Front Desk with any changes in your contact information, insurance, debit/credit card details, marital status, employment, medical issues, etc.

***** Please cancel your appointment only for urgent or unexpected circumstances and emergencies. *****

Acknowledged, read and agreed by: _____

Patient Signature Date

LifeWorks Chiropractic
DR. JUSTIN THOLE, D.C.

Dr Kyle Reynolds DC

2032 Lowe Street, Suite 102, Fort Collins, CO 80525 Tel: (970)377-1810 Fax: (970)377-1815 lifeworks-chiropractic.com

I have both read and understand the Notice of Privacy Practices Act. No personal information will be given out unless I give permission to do so for medical purposes. I understand that some insurance companies require information for their records in order to make payments towards my account.

Name _____

Birth Date _____

Signature _____

Date _____