LifeWorks Chiropractic Clinic

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) _____

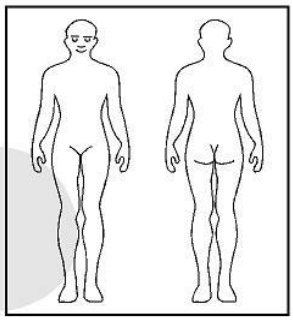
Patient Condition

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

Allergies

Vitamins/Herbs/Minerals

Pharmacy Name _____

Pharmacy Phone (____) _____

Pharmacy E-Mail _____

Office Financial Policy

Cash:

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

Insurance:

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.

2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care we will continue to file your insurance but require full payment per visit or a new treatment plan to be established.

3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

5. Any services deemed "non-covered" or services exceeding benefit limits related to your insurance will be the patient's responsibility.

6. The office will resubmit a claim one time. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by a doctor, the bill is due and payment in full immediately; regardless of any claims submitted.

8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

I have read and understand the Financial Policy and agree to abide by these terms.

Patient Signature: _____ Date: _____

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 inching
- ☐ 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 breath 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

<u>Urination is</u>
- ☐ Frequent
- ☐ Normal
- ☐ Infrequent

<u>The amount is</u>
- ☐ 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

<u>Diet is</u>
- ☐ Balanced
- ☐ Not balanced

<u>Rest is</u>
- ☐ Sufficient
- ☐ Not sufficient

<u>Recreation is</u>
- ☐ Sufficient
- ☐ Not sufficient

<u>My Family Stress is</u>
- ☐ Severe
- ☐ Moderate
- ☐ Minimal
- ☐ None

<u>How do you like your work?</u>
- ☐ I like it very much
- ☐ It's ok
- ☐ I hate it

<u>My job stress is</u>
- ☐ 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
- ☐ Pervious 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

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____