lifelogic
health center, llc
chiropractic, nutrition, lab analysis

Patient Intake

Date: _____ Referred By: _____

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: _____

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

❑ Pregnant; # weeks:_____ ❑ Planning to become pregnant;

Approximately when: _____

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?
_____	_____	_____
_____	_____	_____
_____	_____	_____

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
4. Issue_____ When _____ Hospitalized? Y / N
5. Issue_____ When _____ Hospitalized? Y / N

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

1. What: _____ When: _____ Diagnosed by: _____
2. What: _____ When: _____ Diagnosed by: _____

Name: _____

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 <u>unexplained or rapid</u> weight changes in the last six months? Y / N _____ lbs

List the #1 reason you want to start care at LifeLogic Health Center: _____

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? _____

Name: _____

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

Do you currently have or have you experienced ANY of the following within in the past 2 years?

Mark "N" for now and/or "P" for in the past 2 years.

GENERAL
Fainting _____ Fatigue _____ Fever _____ Headache _____ Migraine _____ Polio _____
Nervousness _____ Numbness in Hands &/or Feet _____ Night Sweats _____ Acne/Blemishes _____
Rashes _____ Addiction _____ Anemia _____ Alcoholism _____ Bleeding Disorder _____ Cancer _____
Blood Clots _____ Diabetes _____ Depression _____ Eczema _____ Eating Disorder _____
Glaucoma _____ HIV+ _____ Hernia _____ Influenza _____ Liver Disease _____ Low Back Pain _____
Mental Illness _____ Hyperthyroidism _____ Goiter _____ Gout _____ Hypothyroidism/Hashimoto's _____
Measles _____ Mumps _____ Chronic Fatigue Syndrome _____ Parkinson's _____ Alzheimer's _____
Dementia _____ Lyme Disease _____ Multiple Sclerosis _____ Mark **X** if you have read all above conditions _____

EYES/EARS/NOSE/THROAT
Lazy Eye _____ Crossed Eyes _____ Double Vision _____ Blurred Vision _____ Vision Loss _____
Deafness _____ Hearing Loss _____ Ear Pain _____ Ear Infection _____ Ringing in Ears _____
Nose Bleeds _____ Sinus Infections _____ Sore Throat _____ Difficulty Swallowing _____
Thyroid Problems _____ Mark **X** if you have read all above conditions _____

RESPIRATORY
Wheezing _____ Bronchitis _____ Pleurisy _____ Pneumonia _____ Asthma _____ Chronic Cough _____
Difficulty Breathing _____ Coughing/Spitting Blood _____ Shallow Breathing _____ COPD/Emphysema _____
Excessive Mucous/Phlegm _____ Mark **X** if you have read all above conditions _____

CARDIOVASCULAR
High Blood Pressure _____ Low Blood Pressure _____ Pain Over Heart _____ Cold Hands/Feet _____
Chest Pain _____ Shortness of Breath _____ Poor Circulation _____ Rapid Heartbeat _____ TIA _____
Slow Heartbeat _____ Stroke _____ Swollen Ankles _____ Varicose Veins _____ Aortic Aneurysm _____
Bruise Easily _____ Heart Disease _____ High Cholesterol _____ Previous Heart Problem _____ → (Please
Describe _____) Mark **X** if you have read all above conditions _____

GASTRO-INTESTINAL
Appendicitis _____ Abdominal Surgery _____ Rectal Surgery _____ Rectal Bleeding _____ Gas _____
Colon Issues _____ Constipation _____ Diarrhea _____ Gallbladder Issues _____ Gall Stones _____
Hemorrhoids _____ Liver Issues _____ Nausea _____ Stomach Ache _____ Poor Appetite _____
Poor Digestion _____ Vomiting _____ Vomiting Blood _____ Bloating _____ Food Sensitivities _____
Crohn's Disease _____ Colitis _____ Colon Cancer _____ IBS _____ Celiac Disease _____ Burping _____
Heartburn _____ Bad Breath _____ Ulcer _____ Constant Hunger _____ Constant Feeling of Fullness _____
Mark **X** if you have read all above conditions _____

Name: _____

GENITO-URINARY

Blood in Urine _____ Frequent Urination _____ Inability to Control Urine _____ Kidney Infection _____
Painful Urination _____ UTI _____ Bladder Infection _____ Kidney Stones _____ Kidney Disease _____
Wake During Night to Urinate _____ Mark **X** if you have read all above conditions _____

MUSCLE/JOINT/BONE

Arthritis _____ Rheumatoid Arthritis _____ Backache _____ Foot Issues _____ Pain Between Shoulders _____
Stiff Neck _____ Painful Tailbone _____ Scoliosis _____ Swollen Joints _____ Osteoporosis _____
Fibromyalgia _____ Broken Bones _____ Joint Replacement _____ Stiff Joints _____ Deep Bone Pain _____
Unexplained Muscle Soreness _____ Popping/Cracking Joints _____ Self-Adjusting _____→ (times/day _____)
Mark **X** if you have read all above conditions _____

NEUROLOGICAL

Epilepsy _____ Seizures _____ Dizziness _____ Hand Trembling _____ Weakness _____ Blackouts _____
Difficulty with Speech _____ Memory Loss _____ Loss of Coordination _____ Movement Disorder _____
Sleeplessness _____ Narcolepsy _____ AD/HD _____ Dyslexia _____ Balance Issues _____ Vertigo _____
Muscle Twitches _____ Abnormal Sensations _____ Numbness _____ Sensitivity to Light _____
Radiating Pain _____ Pins/Needles _____ Loss of Smell _____ Concussion/Head Injury _____
Car Sickness _____ Mark **X** if you have read all above conditions _____

FOR MEN ONLY

Lump in Testicle _____ Penis Discharge _____ Erectile Dysfunction _____ Numbness in Inner Thighs _____
Prostate Issues _____ Enlarged Breast Tissue _____ "Beer Belly" _____ Emotional _____
↓ Sex Drive _____ Date of Last Prostate Exam _____ Mark **X** if you have read all above conditions _____

FOR WOMEN ONLY

Menstrual Cramps _____ Excessive Menstrual Flow _____ Irregular Cycle _____ Painful Periods _____
Lack of Period _____ Birth control Pills _____ Abnormal Pap Smear _____ Miscarriage _____
Fluctuation in Weight During Period _____ Skin Blemishes During Period _____ Vaginal Dryness _____
Painful Intercourse _____ Ovarian Cyst _____ Uterine Fibroid _____ Cancer _____ Lump in Breast _____
Inability to Become Pregnant _____ Yeast Infection _____ Discharge from Nipples _____ Facial Hair _____
Loss of Hair _____ Decreased Sex Drive _____ C-Section _____ Vaginal Birth _____ PMS _____
Over Emotional _____ Mark **X** if you have read all above conditions _____

Family History

Mother- Passed Away / Alive ; Medical Conditions: _____

Father- Passed Away / Alive ; Medical Conditions: _____

Maternal Grandmother- Passed Away / Alive ; Medical Conditions: _____

Maternal Grandfather- Passed Away / Alive ; Medical Conditions: _____

Paternal Grandmother- Passed Away / Alive ; Medical Conditions: _____

Paternal Grandfather- Passed Away / Alive ; Medical Conditions: _____

Sibling Medical Conditions: _____

How long has it been since you have felt at your best? _____

Name: _____

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: _____