

Life Quest Chiropractic & Rehabilitation

510 22nd Avenue East, Suite 701 Alexandria, MN 56308 Phone: 320-763-9711 Fax: 320-762-1278

Registration

Name: _____ M / F
 First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Birthdate: _____

SS#: _____ - _____ - _____ Email: _____

Medical Doctor: _____ Clinic: _____ OK to contact him/her? Y / N

Occupation: _____ Employer: _____ Phone: _____

Marital Status: M S D W Children (name and age): _____

Spouse: _____ Spouse's Employer: _____

How did you hear about us? Yellow Pages Newspaper Internet Screening Radio TV Employer

I was referred by: _____

Please present your Photo ID and Insurance Card to the Front Desk. Thank you.

Assignment and Release

- 1) I hereby consent to treatment by the doctor of Life Quest Chiropractic and Rehabilitation. if applicable, I hereby consent to have treatment for my minor child(ren).
- 2) I hereby give consent to publish x-rays, testimonial or case study as a result of treatment.
- 3) I, the undersigned, certify that I (or my dependent) have personal health insurance coverage with _____ and assign directly to Life Quest all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible for all charges accrued whether or not paid, or covered, by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Health Information Consent Form

I, the patient, understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. Life Quest wants you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of you Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to have access to your medical records, please inform the assistant at the Front Desk.

Signature

Date

Signature of Parent or Guardian of under 18

Date

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CONFIDENTIAL PATIENT CASE HISTORY

Chart _____

Name: _____
First Middle Last

What is your major complaint? _____

How long have you had this condition? _____

What do you think caused this condition? _____

What, if any, positions make it worse? _____

What, if any, positions make it better? _____

Is this condition: Getting Better Getting Worse Staying the Same

Is this condition interfering with: Work Sleep Daily Routine Other _____

Other doctors or therapists that have treated this condition? _____

Please list any past surgeries with year: _____

Prescriptions currently taken: _____

Vitamin supplements currently taken: _____

MARK THE AREA OF YOUR SYMPTOMS ON THE FIGURE

Use the following symbols to describe:

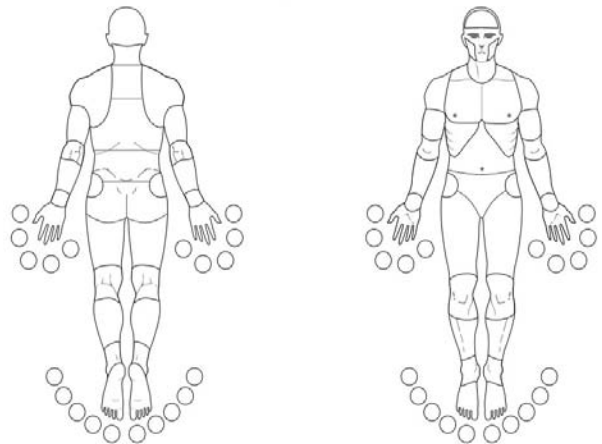
Aches ^^^^ Numbness oooo Tingling xxxx Pain ////

How bad are your symptoms now?

0 1 2 3 4 5 6 7 8 9 10
no pain severe

How bad have they been in the past?

0 1 2 3 4 5 6 7 8 9 10
no pain severe



SOCIAL HISTORY

Mental Work Heavy Moderate Light Hours per day _____

Physical Work Heavy Moderate Light Hours per day _____

Exercise Heavy Moderate Light Hours per day _____

Smoking Current Previous Packs/Day _____ No. of Years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____

Caffeine Coffee/Tea Soda Servings/Day _____

Aspirin/Tylenol/Ibuprofen Amount/Day _____ How long? _____

Review of Systems

Check only the ones you now have or have had in the past.

Musculo-Skeletal System

- Low back pain
- Pain between shoulders
- Neck pain
- Arm/Hand problems
- Shoulder problems
- Leg/Hip problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Difficulty walking
- Fracture
- Arthritis

Genito-Urinary System

- Bladder trouble
- Excessive urination
- Incontinence
- Painful urination
- Discolored urine
- Difficult urination

Female Only

- Vaginal discharge
- Excessive bleeding
- Vaginal pain
- Breast pain
- Lump on breast

Are you pregnant?

- Yes No

Gastro-Intestinal System

- Poor appetite
- Excessive hunger
- Difficulty swallowing
- Excessive thirst
- Nausea
- Vomiting
- Abdominal Pain
- Diarrhea
- Constipation
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder trouble
- Indigestion
- Acid Reflux
- Diabetes

Nervous System

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Light Headedness
- Headaches
- Migraines
- Convulsion
- Seizures
- Memory problems
- Confusion
- Depression
- Anxiety
- Insomnia
- Fatigue

Cardio-Vascular

Respiratory System

- Chest pain
- Difficulty breathing
- Persistent cough
- Excessive phlem
- Asthma
- Rapid heartbeat
- High blood pressure
- Low blood pressure
- Heart condition
- Lung condition
- Varicose veins

EENT

Systems

- Eye strain
- Vision problems
- Ear pain
- Ringing in ear
- Ear discharge
- Hearing loss
- Nose bleeds
- Nasal discharge
- Sore gums
- Hoarseness
- Sore throat

Past Medical History

Check only those that you have had in the past.

- Hay Fever
- Mumps
- Allergies
- Angina
- Cancer
- Tumor
- Heart trouble
- Phlebitis
- Stroke
- Ulcers
- Gall stones
- Epilepsy
- Polio
- Prostate Problems
- Kidney stones
- Disc herniation
- Heart Attack
- Shingles
- STD
- Hepatitis
- Colon problems
- Alcoholism

When was your last visit to a Doctor of Chiropractic? _____

What type of treatment was given? _____

How satisfied were you with the treatment? Very Satisfied Somewhat Satisfied Not at all

What alternative healing methods have you used in the past? (circle all that apply)

Massage Acupuncture Essential Oil Therapy Nutritional Therapy Physical Therapy

Signature _____ Date _____

Parent/Guardian _____ Date _____

Patient Name _____ Chart # _____ Date _____