123 3rd Avenue East · Suite 100 · Alexandria, MN 56308
Ph: 320-762-0683 Fax: 320-227-3558
www.lifequestchiro.com

Name: ______________________ **Birthdate:** ____/____/____ **Gender:** F / M

Address: ______________________ **City:** ______________ **State:** ______ **Zip:** ____________

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________ **SSN:** ____________

Preferred method of communication: Email / Phone / Mail / Text **Medical Doctor:** ______________ **May we contact:** Y/N

Email: ______________ **Occupation:** ______________ **Employer:** ______________

Marital Status: M/S/W/D **Spouse:** ______________ **Spouse's Employer:** ______________ **Number of Children:** ____

Medication Name (provide list if available)	**Dosage and Frequency** (i.e. 5mg once a day, etc.)

Nutritional Supplement Name (provide list if available)	**Dosage and Frequency** (i.e. 5mg once a day, etc.)

Medication Allergy	Reaction	Onset Date	Additional Comments

Is your condition a result of: □ Car Accident: □ Work Injury **Date of Injury:** ______________ **Injury Report Filed:** □ Yes □ No

How did you hear about us? □ Yellow Pages □ Internet □ TV □ Doctor □ Print Ad □ Event □ Friend/Family/Other

□ Google □ Direct Mail □ Insurance Handbook □ Other: ______________

If referred by family/friend/other, their name: ______________________________

Assignment and Release:

I hereby consent to treatment by the doctor(s) at Life Quest Chiropractic & Sports. If applicable, I hereby consent treatment for my minor child(ren).

I understand, certify that I (or my dependent) have personal health insurance coverage with ______________ and assign directly to this office 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.

We accept Health Savings Account (HSA) as a form of payment. Please let us know if you have a HSA account.

Patient Signature: ______________________________ **Date:** ______________

Patient Current Health Condition:

What is your major complaint: ______________________________

How long have you had this condition: ________ Is this condition: □Getting better □Getting worse □Staying the same

What do you think caused this condition: ______________________________

What makes this condition worse: ______________________________

What makes this condition better: ______________________________

Is this condition interfering with: □Work □Sleep □Daily routine □Other: ____________

Other doctors/therapists that have treated this condition: ______________________________

Other healing methods you used for this condition: □Massage □Acupuncture □Physical Therapy □Nutritional Therapy

Mark the area of your symptoms on the figure below: Aches: ^^^^ Numbness: 0000 Tingling: xxxx Pain: ////

How bad are your symptoms now:

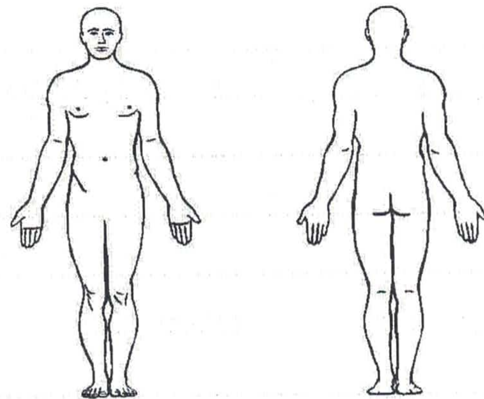
____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe

How bad have your symptoms been in the past:

____

No Pain 0 1 2 3 4 5 6 7 8 9 10 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: ____________	
	□Yoga	□Pilates	□Weights	□Cardio	□Other: ________
Smoking Status:	□Current	□Previous	Packs per day ______	No. of years: ________	
Alcohol:	Beer/Wine ____________		Liquor per week ____	No. of years: ________	
Caffeine:	Coffee/Tea ____________		Soda __________	Servings per day: ________	
Aspirin/Tylenol/Ibuprofen:	Amount per day ____________			How long ____________	

Chart Number: ____________

Review of Systems and Symptoms: Check only the ones you have had in the past or are currently having.

Musculo-Skeletal System

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

Genito-Urinary System

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

Female Only

□Breast Pain
□Excessive bleeding
□Lump on breast
□Vaginal discharge
□Vaginal pain

Are you pregnant?

□Yes □No

Date of last cycle: ___________

Gastro-Intestinal System

□Abdominal pain
□Acid reflux
□Bloody stool
□Constipation
□Diabetes
□Diarrhea
□Difficulty swallowing
□Excessive hunger
□Excessive thirst
□Gall bladder trouble
□Hemorrhoids
□Indigestion
□Liver trouble
□Nausea
□Poor appetite
□Vomiting

Nervous System

□Anxiety
□Confusion
□Convulsion
□Depression
□Dizziness
□Fatigue
□Headaches
□Insomnia
□Light headedness
□Loss of feeling
□Memory problems
□Migraines
□Numbness
□Paralysis

Cardio-Vascular/Respiratory System

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

EENT System

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

Past Medical History: Check only the conditions you have had in the past.

□Alcoholism
□Cancer
□Epilepsy
□Heart attack
□Kidney stones
□Polio
□STD
□Ulcers

□Allergies
□Colon problems
□Gall stones
□Heart trouble
□Mumps
□Prostate Problems
□Stroke

Date of last physical: ___________

□Angina
□Disc herniation
□Hay fever
□Hepatitis
□Phlebitis
□Shingles
□Tumor

Surgeries: Please include implants/cosmetic surgery.

____

____

Chart Number: _________