New Patient Intake Form

Date: ____________________

Name: ____ **Address:** ____

City: ____ **State:** ________ **Zip:** _______________

Home Phone: _________________________ **Work Phone:** _________________________ **Cell Phone:** ______________________

Email Address: ____

*****If the patient listed above is a minor: I, the Legal Guardian/Representative of the patient listed above, hereby give my consent for the doctor at LifeTree Chiropractic & Wellness, to treat my son/daughter.** ____

Social Security Number: __________________________ **Birth Date:** _________________ **Age:** ________ **Male / Female**

Single / Married / Divorced / Widowed Significant Other's Name: ____

Name of Children and Ages: ____

Your Occupation: ___________________________________ **Employer:** ____

How were you referred to Us? ____________________ **Have you received Chiropractic Care before?: Y / N When?:**_________

Emergency Contact Name: ____________________________________ **Phone Number:** _________________________________

Race: ______________________________ **Ethnicity:** ____________________________ **Language:** ________________________

GOALS FOR CARE

People see Chiropractors for a variety of different reasons. Some go for relief of pain, some to correct the cause, and others for prevention. Your doctor will weight your needs and desires when recommending your health program. Please check the type of care desired so we may be guided by your wishes whenever possible.

- ☐ **Relief Care – Symptomatic relief of pain or discomfort.**
- ☐ **Corrective Care – Correcting, relieving, stabilizing the cause of the problem.**
- ☐ **Prevention – Maintaining the body to the highest degree of heath possible.**
- ☐ **I want the doctor to select the type of care appropriate for my condition.**

List any other Doctors you have consulted for this condition:

1. _______________________ **City:** ____________________ **2.** _______________________ **City:** _________________________

Do you have health insurance? Y N Insurance Company Name: ____
If needed, do we have your permission to send information regarding your care to your primary physician? Y N
Is this injury work related? Y N Is this injury related to an auto accident? Y N If YES, date of injury: __________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know 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 your 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 receive your medical records, please inform our office.

Patient signature ____ **Date:** ______________

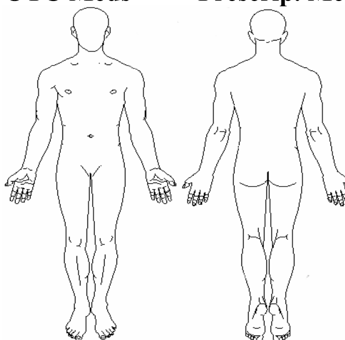
OUT OF POCKET EXPLANATION: Certain insurance providers and some laws may require us to report any services, including diagnostic services; you receive at LifeTree Chiropractic & Wellness, LLC. If you have an offer for any promotional rate for an initial visit to the Clinic, you, the patient will pay no more than the cost stated in the advertisement, and your insurance carrier will be billed for any charges above the advertised cost.

HEALTH QUESTIONAIRE

First Area of Complaint

What is you primary area of complaint? ______________________________
How often does it bother you? ______________________________
How long or what is the duration it bothers you? ______________________________
On a scale of 1 to 10 (10 being the worst), what does it feel like at its worse? 1 2 3 4 5 6 7 8 9 10
Does the pain travel to any other part of the body? ______________________________
Are there any positions that give relief? ______________________________
What have you tried that hasn't helped? Ice Heat OTC Meds Prescrip. Meds: ______________

Where is your Pain now?



Second Area of Complaint

What is your primary area of complaint?______________________________
How often does it bother you? ______________________________
How long or what is the duration it bothers you? ______________________________
On a scale of 1 to 10 (10 being the worst), what does it feel like at its worse? 1 2 3 4 5 6 7 8 9 10
Does the pain travel to any other part of the body? ______________________________
Are there any positions that give relief? ______________________________
What have you tried that hasn't helped? Ice Heat OTC Meds Prescrip. Meds: ______________
Have you had any previous injuries? If so, explain: ______________________________

Have you had any hospitalizations or surgeries? If so, explain: ______________________________

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Have you had any non-work or non-auto accidents or falls? If so, explain: ______________________________

Have you had any work or auto accidents? If so, explain: ______________________________

Have you had headaches?	**Yes**	**No**	**How Often?** ______________
Have you had dizziness?	**Yes**	**No**	**How Often?** ______________
Have you had blurred vision?	**Yes**	**No**	**How Often?** ______________
Have you had loss of concentration?	**Yes**	**No**	**How Often?** ______________
Have you had depression?	**Yes**	**No**	**How Often?** ______________
Have you had nervousness?	**Yes**	**No**	**How Often?** ______________
Have you had difficulty sleeping?	**Yes**	**No**	**How Often?** ______________
Have you had difficulty falling asleep?	**Yes**	**No**	**How Often?** ______________
Have you been waking Often?	**Yes**	**No**	**How Often?** ______________
Do you have low energy or feel run down?	**Yes**	**No**	**How Often?** ______________
Have you been tired in the morning?	**Yes**	**No**	**How Often?** ______________
Have you had a buzzing or ringing in you ears?	**Yes**	**No**	**How Often?** ______________
Have you had fainting spells?	**Yes**	**No**	**How Often?** ______________
Have you had palpitations?	**Yes**	**No**	**How Often?** ______________

Are you currently experiencing any problems in the following areas?

Allergies or sinus	**Yes**	**No**	**Colon**	**Yes**	**No**	**Heart or HBP**	**Yes**	**No**
Pain or stiff neck	**Yes**	**No**	**Low Back**	**Yes**	**No**	**Stomach**	**Yes**	**No**
Right Shoulder	**Yes**	**No**	**Hips**	**Yes**	**No**	**Bladder**	**Yes**	**No**
Left Shoulder	**Yes**	**No**	**Chest Pain**	**Yes**	**No**	**Liver**	**Yes**	**No**

Neck Disability Index Questionnaire

Patient Name: ________________________________ **Date:** ____________________

Please read carefully:

This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box which most closely describes your problem right now.

Section 1 – Pain Intensity

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help but manage most of my personal care.
E. I need help everyday in most aspects of my life.
F. I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain.
C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, i.e. a table.
D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

Section 4 – Reading

A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I can not read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

Section 5 – Headaches

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

Section 6 – Concentration

A. I can concentrate fully when I want with no difficulty.
B. I can concentrate fully when I want with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to

Section 7 – Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

Section 8 – Driving

A. I can drive without any neck pain.
B. I can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

Section 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr. sleepless).
C. My sleep is mildly disturbed (1-2 hrs. sleepless).
D. My sleep is moderately disturbed (2-3 hrs. sleepless).
E. My sleep is greatly disturbed (3-5 hrs. sleepless).
F. My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

A. I am able to engage in all my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I cannot do any recreation activities at all.

Other Comments:

____
____
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____
____
____

Examiner: ____________________________________

Back Disability Index Questionnaire

Patient Name: ________________________________ **Date:** ____________________

Please read carefully:

This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box which most closely describes your problem right now.

Section 1 – Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing and dressing without help.

Section 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor,
D. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, i.e. a table.
E. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights at the most.

Section 4 – Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than 1/2 mile.
D. Pain prevents me from walking more than 1/4 mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

A. I can sit in a chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than 1 hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

Section 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than 1/2 hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

Section 7 – Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarter.
F. Pain prevents me from sleeping well.

Section 8 – Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases my degree of pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
D. Pain has restricted my social life and I do not go out often.
E. Pain has restricted my social life to my home.
F. I hardly have any social life because of the pain.

Section 9 – Traveling

A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that are done lying down

Section 10 – Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better or worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Other Comments:

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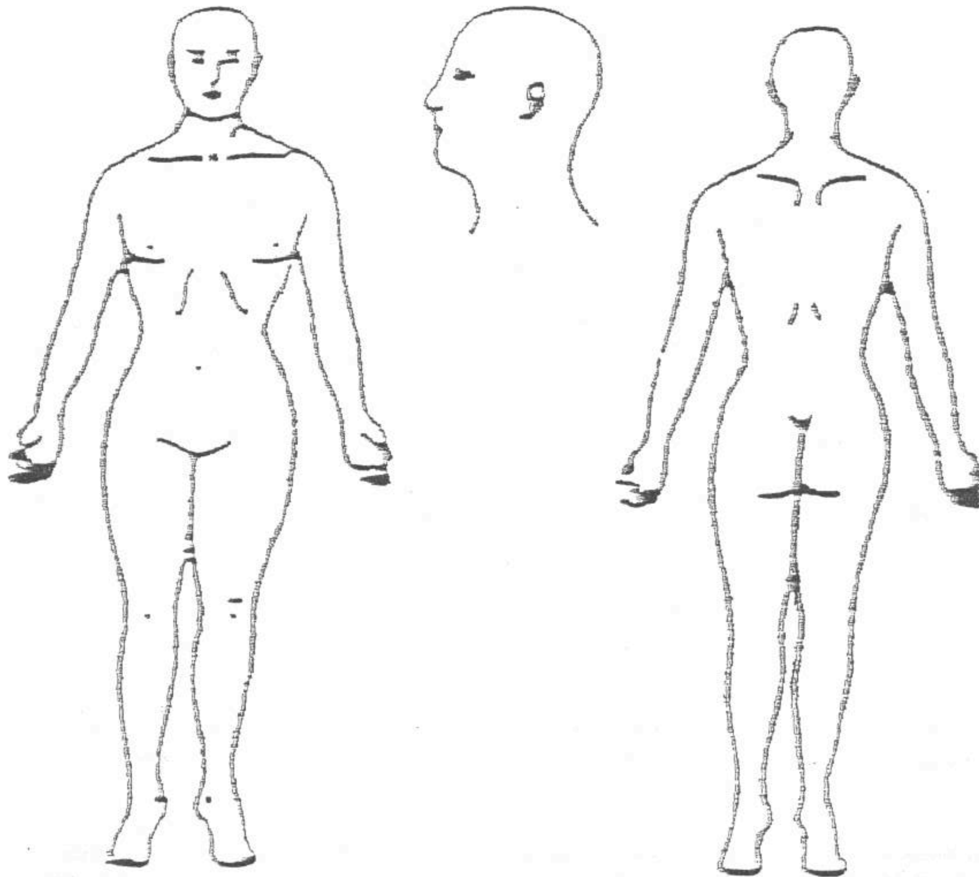
____

Name ______________________________ Date ______________

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches /\/\/\/\ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



Indicate the severity of your symptoms by marking an "X" on the lines below:

How bad are your symptoms now?

None ______________________________ Most Severe

How bad have they been in the past?

None ______________________________ Most Severe

Reference: Ransford, Spine, Vol. 1, No 2, June 1976

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Acknowledgement of Financial Responsibility

Non-Covered Services Annual Disclosure Form

As your Doctor of Chiropractic, I want to provide you with the best possible care. There are services that I feel are in your best interest for the treatment of your condition and maintenance of good health that may not be covered by your health insurance coverage. You will be expected to pay for those services in full. Let me reassure you that I will only provide care that I feel is necessary.

Covered services traditionally include:

- Treatment that has the potential to significantly improve a clinical problem
- Limited treatment of symptom flare-ups or exacerbations where a permanent condition exists.

Services not traditionally covered include:

- ✓ Some diagnostic services
- ✓ Some durable medical products (including braces, ice packs, etc.)
- ✓ Maintenance care aka elective care.
- ✓ Some therapeutic services which include but are not limited to: laser, electric stimulation, and acupuncture.

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services. I understand that .665% interest will be added monthly to all balances 60 days and older.

________________________________ ____________________

Patient Signature Date

Provider Information:
LifeTree Chiropractic & Wellness, LLC
3550 Lexington Ave. N., Ste 210
Shoreview, MN. 55126