



We, the clinic faculty and staff, are committed to serve our community in a professional clinical environment and to empower patients to actively participate in their healthcare. The Life University Clinics recognize and respect the self-aware, self-directed, self-maintaining, self-healing, and self-improving nature of life and living beings.

If you have been involved in an auto accident or a work injury please speak to one of the office assistants before completing this form.

This section is be completed by the Staff.
Date: Faculty Clinician: No.
Intern Name: Intern No.

SECTION 1

Personal Data

Patient Name: First Last M.I.

Prefers to be called Birth Date M F

Parent or Guardian's Name if the Patient is a Minor:

Are you currently pregnant? Yes No Maybe. Have you ever been pregnant? Yes No

Home Address:

City: State: Zip:

Phone: Home: Work: Mobile:

E-mail:

Current Employer Contact Phone:

Work Address:

City: State: Zip:

Job Description

Marital Status: Single Married Divorced Widowed

Spouse/Partner Name: Spouse's Employer:

Number of Children: Ages:

Emergency Contact Person: Phone :

SECTION 2

Reason for Care: I am here for a Specific Condition Yes No *If No please go directly to SECTION 3*

Primary Complaint	Secondary Complaint	Tertiary Complaint
Briefly describe complaint: _____ _____	Briefly describe complaint : _____ _____	Briefly describe complaint : _____ _____
<p style="text-align: center;">PAIN SCALE (CIRCLE)</p> <p style="text-align: center;">BEST WORST</p> <p style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</p>	<p style="text-align: center;">PAIN SCALE (CIRCLE)</p> <p style="text-align: center;">BEST WORST</p> <p style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</p>	<p style="text-align: center;">PAIN SCALE (CIRCLE)</p> <p style="text-align: center;">BEST WORST</p> <p style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</p>
<p>Is it constant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comes & goes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please check ALL that describe your current symptoms?</p> <p><input type="checkbox"/> Sharp <input type="checkbox"/> Pins/Needles <input type="checkbox"/> Stabbing <input type="checkbox"/> Tingling <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Tightness <input type="checkbox"/> Pinching <input type="checkbox"/> Other</p> <p>Please check ALL that aggravate your condition?</p> <p><input type="checkbox"/> Driving <input type="checkbox"/> Breathing <input type="checkbox"/> Walking <input type="checkbox"/> Coughing <input type="checkbox"/> Sitting <input type="checkbox"/> Sleeping <input type="checkbox"/> Bending <input type="checkbox"/> Working <input type="checkbox"/> Standing <input type="checkbox"/> Exercising <input type="checkbox"/> Bowel <input type="checkbox"/> Other Movements</p> <p>What makes your condition better?</p> <p><input type="checkbox"/> Chiropractic <input type="checkbox"/> Stretching <input type="checkbox"/> Rest <input type="checkbox"/> Massage <input type="checkbox"/> Recumbent <input type="checkbox"/> Medication <input type="checkbox"/> Sitting <input type="checkbox"/> Nothing <input type="checkbox"/> Standing <input type="checkbox"/> Other</p> <p>Have you had this current complaint in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? ___/___/___</p> <p>Have you seen any other healthcare providers for your current complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Is it constant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comes & goes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please check ALL that describe your current symptoms?</p> <p><input type="checkbox"/> Sharp <input type="checkbox"/> Pins/Needles <input type="checkbox"/> Stabbing <input type="checkbox"/> Tingling <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Tightness <input type="checkbox"/> Pinching <input type="checkbox"/> Other</p> <p>Please check ALL that aggravate your condition?</p> <p><input type="checkbox"/> Driving <input type="checkbox"/> Breathing <input type="checkbox"/> Walking <input type="checkbox"/> Coughing <input type="checkbox"/> Sitting <input type="checkbox"/> Sleeping <input type="checkbox"/> Bending <input type="checkbox"/> Working <input type="checkbox"/> Standing <input type="checkbox"/> Exercising <input type="checkbox"/> Bowel <input type="checkbox"/> Other Movements</p> <p>What makes your condition better?</p> <p><input type="checkbox"/> Chiropractic <input type="checkbox"/> Stretching <input type="checkbox"/> Rest <input type="checkbox"/> Massage <input type="checkbox"/> Recumbent <input type="checkbox"/> Medication <input type="checkbox"/> Sitting <input type="checkbox"/> Nothing <input type="checkbox"/> Standing <input type="checkbox"/> Other</p> <p>Have you had this current complaint in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? ___/___/___</p> <p>Have you seen any other healthcare providers for your current complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Is it constant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comes & goes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please check ALL that describe your current symptoms?</p> <p><input type="checkbox"/> Sharp <input type="checkbox"/> Pins/Needles <input type="checkbox"/> Stabbing <input type="checkbox"/> Tingling <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Tightness <input type="checkbox"/> Pinching <input type="checkbox"/> Other</p> <p>Please check ALL that aggravate your condition?</p> <p><input type="checkbox"/> Driving <input type="checkbox"/> Breathing <input type="checkbox"/> Walking <input type="checkbox"/> Coughing <input type="checkbox"/> Sitting <input type="checkbox"/> Sleeping <input type="checkbox"/> Bending <input type="checkbox"/> Working <input type="checkbox"/> Standing <input type="checkbox"/> Exercising <input type="checkbox"/> Bowel <input type="checkbox"/> Other Movements</p> <p>What makes your condition better?</p> <p><input type="checkbox"/> Chiropractic <input type="checkbox"/> Stretching <input type="checkbox"/> Rest <input type="checkbox"/> Massage <input type="checkbox"/> Recumbent <input type="checkbox"/> Medication <input type="checkbox"/> Sitting <input type="checkbox"/> Nothing <input type="checkbox"/> Standing <input type="checkbox"/> Other</p> <p>Have you had this current complaint in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? ___/___/___</p> <p>Have you seen any other healthcare providers for your current complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Patient Name: _____ **Date:** _____ **File #:** _____

SECTION 3

Health Habits & Lifestyle Please answer the questions below.

<p>EXERCISE</p> <p>Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How often do you exercise? ___ days/week ___ Hours/day</p> <p>Stretching / Flexibility <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Running / Treadmill/ Walking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rowing / Swimming <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Competitive Athlete <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pilates /Yoga <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Group Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weight Lifting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>OTHER: Please list- _____ _____ _____</p>	<p>DIET</p> <p>Do you have a healthy diet? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How many serving s of fruits & vegetables per day? # _____</p> <p>How many 8oz. glasses of water per day? # _____</p> <p>Do you drink caffeinated beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How many per day? # _____</p> <p>Please List Food Allergies? _____ _____</p> <p>Have you ever had an eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>ALCOHOL/TOBACCO/RECREATIONAL DRUG USE?</p> <p>Do you use any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How many cigarettes do you smoke? _____ /day or _____/wk</p> <p>Do you use smokeless tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How much do you use a day? Cans or pouches _____ /day</p> <p>Do you have history of alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p># drinks ____ /day ____ /wk</p> <p>1 "drink" is equal to 12 oz. can of beer, 1.5 oz. liquor, 80 proof, 5 oz. wine.</p>
<p>DAILY STRESS LEVEL SCALE</p> <p>Low _____ High</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>Have you ever sought help for a mental health issue? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>SLEEPING PATTERN</p> <p>Hours of sleep per night? _____ hours</p> <p>Please circle appropriate sleep quality. Excellent Good Fair Poor</p> <p>Sleep interrupted _____ X/ night</p> <p>How long? ___ wks, ___ months, ___ years</p>	

SECTION 4

Personal Health History Please mark all issues below that you have currently or have had in the past.

C = current P = past If **none** of the below apply please check this box

MUSCLE /JOINT C P Arthritis C P Back Pain C P Sciatic Pain C P Bursitis C P Hip Pain C P Foot Pain C P Neck Pain C P Headache C P Shoulder Pain C P Arm Pain C P Wrist Pain C P	EYES/EARS/THROAT C P Thyroid C P Hearing Difficulty C P Vision C P --- DIGESTIVE C P Stomach C P Intestinal C P Colon C P --- INTERNAL C P Liver C P Gall bladder C P Pancreas C P	SKIN C P Easy Bruising C P Psoriasis/ C P Eczema C P Hives C P Skin Allergy C P Itching C P Varicose C P --- PULMONARY C P Difficulty Breathing C P --- COPD C P Asthma C P Seasonal Allergy C P	CARDIOVASCULAR C P Blood Pressure C P Irregular Heart Beat C P Poor Circulation C P --- URINARY C P Kidney C P Difficulty Urinating C P --- REPRODUCTIVE C P Menstrual C P Pregnancy C P Prostate C P Venereal Disease C P	GENERAL C P Food Allergy C P Dizziness C P Infections C P --- INFECTIOUS DISEASES C P HIV C P Hepatitis C P Tuberculosis C P --- ENDOCRINE C P --- NEUROLOGICAL C P --- PSYCHOLOGICAL C P
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Please list all of the medications you are taking including over the counter medications, herbs & vitamins and nutritional supplements. *If none please write: **None***

Name / Dose / Frequency

Name / Dose / Frequency

Medication Allergies - Please list all below _____

SECTION 5

Please list ALL accidents, injuries, surgeries & hospitalizations. *If none please write: **None***

Accidents, Injuries, Fractures (Dates) _____

Surgeries (Dates) _____

Hospitalizations (Dates) _____

Please list all of your doctors and healthcare providers including previous Chiropractors

Name: _____ Phone # _____

Name: _____ Phone # _____

Name: _____ Phone # _____

SECTION 6

Family History Please mark the appropriate box with an X. If **none** of the below please check this box

HISTORY	Mother	Father	Brother/Sister	Grandmother	Grandfather
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auto immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient General Information Questionnaire

Patient Name: _____ **Date:** _____ **File #:** _____

1. Are you an employee, or related to an employee at Life University? Yes No Relationship: _____
2. Are you a student, or related to a student in any program at Life University? Yes No Relationship: _____
3. Are you a student, or related to a student in a DC Program? Yes No Relationship: _____
4. Do you or a relative plan to enroll as a student in a Doctor of Chiropractic Program? Yes No
If yes, When: _____ and Relationship: _____
5. If you answered yes to 2, 3 or 4: Student's Name: _____ Student ID: _____

Consent for Chiropractic Care in Life University Clinics

Chiropractic care is based on clinical evidence of vertebral subluxations and not the presence or absence of pain, abnormal range of motion, or abnormal spinal curves. By the use of specific analysis and spinal adjustments, the goal of chiropractic is primarily to reduce/correct spinal subluxations.

- The Life University chiropractic clinics are teaching clinics.
- The chiropractic assessment and chiropractic care provided in the Life Clinics may occur in an open environment.
- In some situations, your care will occur in an open environment and personal health information (PHI) may be subject to incidental exposure by others in the clinic setting
- I understand that my records and/or x-rays are the property of Life University and will be used for teaching and research purposes and if at anytime I request a copy of my records and/or x-rays there will be an additional charge for copying them.
- I authorize Life Clinics and its agents to administer care as needed, as indicated from examination findings.
- I authorize Life Clinics to release information to my doctor and/or insurance company.
- I understand that if I am in litigation for any accident my settlement may be jeopardized by the fact that a student is rendering my care in this clinic.
- A parent or an approved individual **MUST** accompany their minor child on every visit to the clinic.
- I acknowledge that I have read Life University's Notice of Privacy Practices (or had the opportunity to read it if I so choose). I have received a summary of Life University's Notice of Privacy Practices and acknowledge that I may have a personal copy of the entire Notice upon request.
- I consent to the use and or disclosure of my protected health information as specified in Life University's Notice of Privacy Practices.

I have read and understand the above.

Patient Signature (custodial parent or legal guardian if patient is a minor)	Relationship to Patient	Date
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Witness Signature	Date	Print Clinician Name - #	Faculty Clinician Signature	Date
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Health is affected by your nervous system, but it is also affected by your environment, the foods you eat, and your lifestyle activities and habits.

Administration Only

PATIENT CATEGORY			
<input type="checkbox"/>	R	Regular	<input type="checkbox"/>
<input type="checkbox"/>	T	Transient	<input type="checkbox"/>
<input type="checkbox"/>	C	Child	<input type="checkbox"/>
<input type="checkbox"/>	P	Employee	<input type="checkbox"/>
<input type="checkbox"/>	G	Gratis	<input type="checkbox"/>
<input type="checkbox"/>	GA	Alumni	<input type="checkbox"/>
<input type="checkbox"/>	LS	LU Student	<input type="checkbox"/>
<input type="checkbox"/>	GM	Medicare	<input type="checkbox"/>
<input type="checkbox"/>			<input type="checkbox"/>
<input type="checkbox"/>	S	DC Student	<input type="checkbox"/>
<input type="checkbox"/>	I	Insurance	<input type="checkbox"/>
<input type="checkbox"/>	TS	Transient DC Student	<input type="checkbox"/>
<input type="checkbox"/>	E	Veteran	<input type="checkbox"/>
<input type="checkbox"/>	O	Employee Family	<input type="checkbox"/>
<input type="checkbox"/>	G1	Partial Gratis	<input type="checkbox"/>
<input type="checkbox"/>	GF	Alumni Family	<input type="checkbox"/>
<input type="checkbox"/>	LF	LU Student Family	<input type="checkbox"/>
<input type="checkbox"/>	NS	College Students	<input type="checkbox"/>
<input type="checkbox"/>	EM	Active Military	<input type="checkbox"/>
<input type="checkbox"/>	F	DC Student Family	<input type="checkbox"/>

How did you hear about us?

- Website
- Friend / Family member
- Intern
- Life Center for seniors
- Health Fair
- Other

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

PHOTO ID