



Monte H. Greenawalt

LIFE WEST HEALTH CENTER

Chiropractic | Health | Wellness

Transfer Forms

(to be used when transferring to a new intern.)



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Instructions for completing our online forms:

1. Open and SAVE THE FORMS to your computer.

***Please note that you could lose all of your data if you fill out the forms in your browser instead of first saving to your computer. The PDF is a fillable form, and the information can be saved when used with Adobe Reader 8 or higher.*

2. Open the file in Adobe Reader 8 or higher or Adobe Acrobat. Complete the form and save.
3. To expedite service please email the completed form as an attachment to HCADMIT@lifewest.edu.
4. Alternatively you may print the forms and bring them with you to your appointment. This may increase the time for our staff to process your paperwork.

REASON FOR SEEKING CARE

Intern: _____ Doc #: _____ Patient: _____ File #: _____ Date: _____

Please describe the symptom(s) of your primary complaint: _____

If you have more than one complaint, fill out an Additional Form for each complaint

I do not have any symptom(s).

ONSET

When did you start to have the symptom(s)? _____

How did the symptoms start? Can you identify a reason for the symptom(s)? _____

If you have had these symptoms before, please describe: _____

PROVOCATIVE

What makes the symptoms worse (check all that apply)?

Sitting Standing Moving Bending Forward Driving Coughing Sneezing Bearing Down
 Other(s): _____

PALLATIVE

What makes it feel better?

QUALITY

Which best describes the quality of the symptoms? Please check all that apply or describe:

Dull Ache Sharp Deep Superficial Burning Numbness Shooting Tingling Stiff Tight

Other: _____

RADIATION

If the symptoms radiate, please describe where: _____

SEVERITY

On a scale of 1 – 10, 10 being the worst pain, what is the level of pain:

____right now ____ at best ____at worst ____most of the time

TIMING

How many days a week do you experience your symptom(s)? _____

On average, how long do you experience your symptom(s) in the course of a 16 hour day?

Infrequent Occasionally Intermittently Frequently Constantly
 (2 hrs of the day) (4 hrs of the day) (8 hrs of the day) (12 hrs of the day) (16 hrs of the day)

Does the **pain** wake you up? Yes No - If yes, does it keep you from sleeping? Yes No

Have you seen any other health care providers for this complaint? Yes No - If yes, please list they type of provider:

Intern Notes:



PATIENT SURVEY

Indicate below, the location and type of pain that is current or ongoing.

Numbness = = = = Pins and Needles o o o o Burning x x x x Stabbing // // // Aching a a a a

Patient Signature: _____ Date: _____
 (PLEASE DO NOT WRITE BELOW THIS LINE)

Intern Comments: _____



WELLNESS QUESTIONNAIRE

Intern: _____ Doc #: _____ Patient: _____ File: _____ Date: _____

Please answer the following questions on a scale of 1-10, 10 being the best:

General State of Well-being _____ General Outlook and Attitude _____

Please answer the following question on a scale of 1-10, 10 being the most stress:

Average Level of Stress _____

In the past 30 days, how many days have you felt healthy and full of energy? _____

In the past 30 days, how many days was your physical health not good? _____

What is your occupation? _____

Please describe your work duties _____

How many hours/week do you work? _____ Are you content with your work? No __ Yes __

If not, please describe _____

What other interests/hobbies do you engage in? _____

Diet and Nutrition: Do you currently follow any of the following special diets or nutritional programs? Circle all that apply:

Vegetarian Vegan Allergy Elimination Low Fat Low Carb High Protein Blood Type Low Sodium No Dairy No Wheat Gluten Free Other: _____

How many of each ½ cup servings/day of fruit: _____ vegetables: _____

How many of each per day (on average) sweets: _____ fast food: _____

How many 8 oz glasses of water do you drink per day? _____

How many meals do you eat out per week? Please circle: 0-1 1-3 3-5 >5 meals per week

Do you have sensitivities/intolerances to certain foods? No __ Yes __ If yes, list food and symptoms:

Do you drink Alcohol? No __ Yes __

If yes: How many alcoholic beverages do you drink in a week? Please circle.

(1 drink = 5 ounces of wine, 12 ounces of beer, or 1.5 ounces of hard alcohol)

None 1-3 4-6 7-10 >10

Do you drink caffeine? No __ Yes __ How often: _____ How many 8 oz cups/day: _____

Circle all that apply:

Coffee Tea Green Tea Energy Drinks Sodas

Do you use tobacco products? No __ Yes __ If so, Number of years _____

What type? Circle all that apply and note amount per day

Cigarettes _____ smokeless pipe _____ cigar _____ e-cig/vape _____

Do you exercise? No __ Yes __ If so, what kind? Circle all that apply:

Cardio/Aerobic Strength/resistance Flexibility/stretching Balance Sports/leisure Other: _____

How many hours of sleep do you get each night? _____ Do you have problems falling asleep? Yes __ No __

Do you have problems staying asleep? Yes __ No __ Is it restful? Yes __ No __

Other concerns?: _____

Please circle all that apply: Do you currently experience **stress, anxiety, depression, or none of the above?**

Are you currently under treatment for it? No __ Yes __

If yes, please describe treatment _____

Do you feel the treatment is effective _____

Patient Signature: _____ Date: _____

Intern Notes: _____

REVIEW OF SYSTEMS

Intern: _____ **Doc #:** _____ **Patient:** _____ **File#:** _____ **Date:** _____

Review of Systems: Please check any conditions or symptoms that apply to you. Please circle (**P**) on the left side if you had the condition over 3 months ago. Circle (**C**) on the right if the symptom or condition is experienced currently. (Current symptoms have been experienced within the past 3 months.)

Injuries/Trauma (list date next to injury):

- | | | |
|----------------------------|-------------------------------|------------------------|
| P C Back injury | P C Head Injury/Concussion | P C Soft tissue injury |
| P C Broken bones/Fractures | P C Industrial accident | P C Sports Injury |
| P C Disability (ies) | P C Joint injury | P C Other |
| P C Fall (severe) | P C Motor Vehicle Injury(ies) | |

Intern notes _____

General History

- | | | |
|-----------------------------|--------------------------------|----------------------------|
| P C Anemia | P C Fatigue/weakness | P C Mental illness |
| P C Bleeding/Bruising | P C Hospitalizations/surgeries | P C Skin lesions/rashes |
| P C Cancer | P C Autoimmune Disease | P C Unexpected Weight gain |
| P C Chills/Fever | P C Night Sweats | P C Unexpected Weight loss |
| P C loss/change of appetite | | |

Intern notes _____

Eyes/Ear/Nose/Throat

- | | | |
|-----------------------------|-------------------------------|----------------------------|
| P C Eye/Visual problems | P C Hearing loss | P C Difficulty swallowing |
| P C Allergies/Sinusitis | P C Ringing in ears/dizziness | P C Frequent sore throats |
| P C Ear discharge/pain | P C Change in smell/taste | P C Swollen/painful glands |
| P C Frequent ear infections | P C Nosebleeds | P C Dental problems |

Intern notes _____

Lung/Respiratory

- | | | |
|---------------------|--------------------------|---------------------------|
| P C Asthma/Wheezing | P C Coughing up blood | P C Toxic fume exposure |
| P C Cough | P C Pneumonia/infections | P C Tuberculosis/exposure |

Intern notes _____

Heart/Cardiovascular

- | | | |
|---------------------------|-----------------------------|---------------------------------------|
| P C Heart disease/surgery | P C High/low blood pressure | P C Swelling of feet/ankles |
| P C Heart murmur | P C Palpitations | P C Shortness of breath with exercise |

Intern notes _____

Stomach/Gastrointestinal

- | | | |
|-------------------------------|-------------------------------|------------------------|
| P C Abdominal pain/swelling | P C Jaundice/liver disease | P C Hemorrhoids |
| P C Heartburn/Ulcer | P C Constipation/diarrhea/gas | P C Rectal bleeding |
| P C Gallbladder disease/Stone | P C IBS/Crohns Disease | P C Black tarry stools |

Intern notes _____

Endocrine

- | | | |
|---------------------------|-----------------------------|------------------------------|
| P C Cold/heat intolerance | P C Excessive hunger/thirst | P C Unusual hair loss/growth |
| P C Diabetes | P C Hormone therapy | P C Voice changes |
| P C Hyper/Hypo Thyroidism | | |

Intern notes _____

Nervous System

- | | | |
|---------------------------|----------------------|--------------------------|
| P C Dizziness/Fainting | P C Loss of memory | P C Slurred speech |
| P C Headache | P C Numbness | P C Stroke |
| P C Loss of consciousness | P C Seizures/Tremors | P C Unsteadiness of gait |

Intern notes _____

REVIEW OF SYSTEMS

Intern: _____ **Doc #:** _____ **Patient:** _____ **File #:** _____ **Date:** _____

Urinary System

- | | | |
|---------------------------------|--------------------------------|----------------------------|
| P C Chronic bladder infections | P C Frequent/painful urination | P C Pelvic/Flank pain/mass |
| P C Difficulty starting/holding | P C Kidney disease | P C Blood in urine |

Intern notes _____

Female History

- | | | |
|---|------------------------------|---------------------|
| P C Abnormal vaginal bleeding/discharge | P C Cramps/pelvic pain | P C Hormone therapy |
| P C Irregular menstruation | P C Fibroids/ovarian cyst | P C Hysterectomy |
| P C Breast lump/pain | P C Heavy menstrual bleeding | P C STD/STI |
| P C Frequent Yeast Infection UTI | | |

Concerns about your reproductive health: _____

(Circle Y for Yes, N for No)

- | | |
|------------------------------|--|
| Y <u>N</u> I am pregnant | Y <u>N</u> I do have osteoporosis/penia |
| Y <u>N</u> I am in menopause | Y <u>N</u> Birth control/method/How long _____ |

If you have been pregnant in the past, please fill in the appropriate information below.

- | | |
|---|--|
| _____ Number of complicated pregnancies | _____ Number of uncomplicated pregnancies |
| _____ Number of terminated pregnancies | _____ Number of vaginal deliveries |
| _____ Number of C-sections | _____ Number of miscarriages |
| Last PAP date _____ Normal: Y <u>N</u> | Last Mammogram date _____ Normal: Y <u>N</u> |

Intern notes _____

Male History

- | | | |
|--------------------------------|----------------------------------|---------------------|
| P C Burning/frequent urination | P C Hesitancy/dribbling | P C Urine retention |
| P C Erectile dysfunction | P C Prostate disease/Enlargement | P C STD/STI |
| P C Testicular mass/pain | P C Last PSA test date _____ | |

Concerns about your reproductive health: _____

Family History: Please write who the relation is and how old they were when had the disease.

- | | |
|----------------------------------|-------------------------------|
| P C Alzheimers _____ | P C Headache _____ |
| P C Backache _____ | P C Heart disease _____ |
| P C Cancer _____ | P C High Blood Pressure _____ |
| P C Depression _____ | P C Stroke _____ |
| P C Dementia _____ | P C Tremors _____ |
| P C Diabetes Type 1/Type 2 _____ | |

Intern notes _____

Medical History

- Date of last physical exam and reason: _____
 Date of last X-ray taken and reason: _____
 Date of last MRI/CT taken and reason: _____
 Date of last labs taken and reason: _____

Bone Density/ DEXA: _____

- Have you ever experienced an aortic dissection aneurism? Y N
 Is there a family history of aortic dissection aneurism? Y N
 Is there a family history of Collagen disorders (i.e. Marfan's Syndrome)? Y N
 Have you had disabling neck or arm pain, headache or concussion within past 6 months? Y N

Please list all current medications and supplements taken. Include frequency and dosage if known.

<u>Medication/Vitamin Name</u>	<u>What Condition</u>	<u>Quantity/dosage</u>	<u>How often</u>	<u>Why/When did you start taking?</u>
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____