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.

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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:

_____

_____

_____

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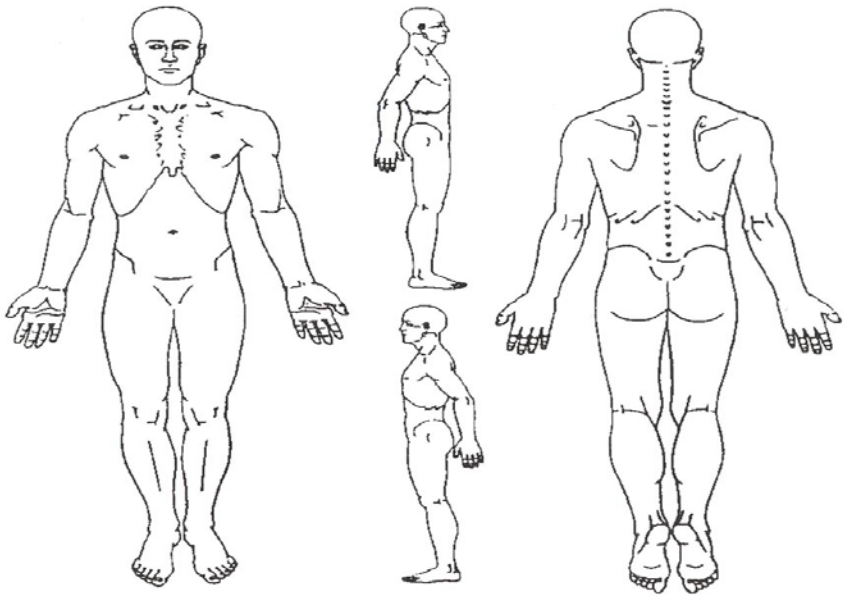
PATIENT SURVEY

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: _____

_____

_____

_____

_____

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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:_____

_____

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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 _____

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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 N I am pregnant Y N I do have osteoporosis/penia
Y N I am in menopause Y N 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 N Last Mammogram date _____ Normal: Y N

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 I/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.

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