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.

January 2017

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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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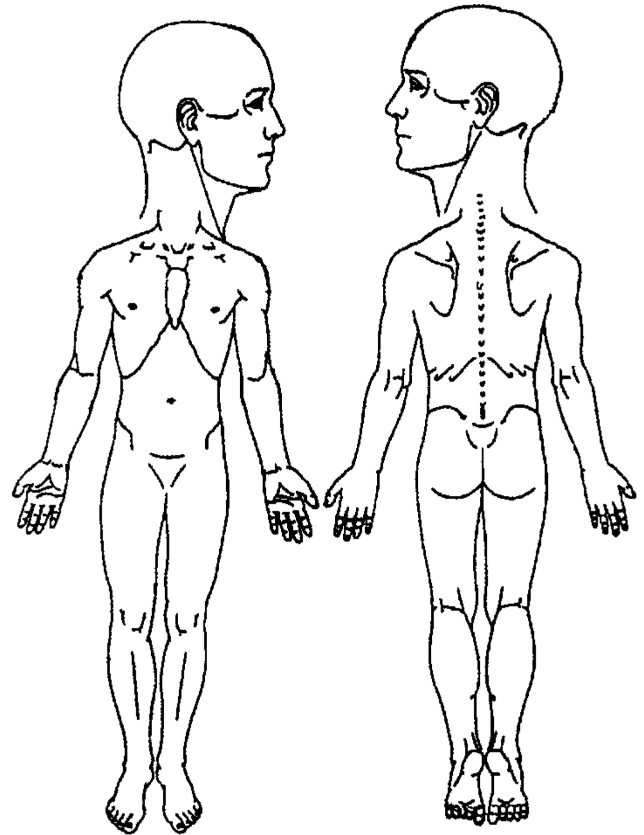
SHORT FORM MCGILL PAIN QUESTIONNAIRE AND PAIN DIAGRAM

Intern: ___________ Doc #:_________ Patient: _________________ File #:_________ Date: _______________

Check the column to indicate the level of your pain for each word, or leave blank if it does not apply to you.

Please complete for your chief complaint ONLY

		Mild (= 1)	Moderate (= 2)	Severe (= 3)
Sensory Report				
1	Throbbing	_____	_____	_____
2	Shooting	_____	_____	_____
3	Stabbing	_____	_____	_____
4	Sharp	_____	_____	_____
5	Cramping	_____	_____	_____
6	Gnawing	_____	_____	_____
7	Hot-burning	_____	_____	_____
8	Aching	_____	_____	_____
9	Heavy	_____	_____	_____
10	Tender	_____	_____	_____
11	Splitting	_____	_____	_____
Affective Report				
12	Tiring-Exhausting	____	_____	____
13	Sickening	_____	_____	_____
14	Fearful	_____	_____	_____
15	Cruel-Punishing	_____	_____	_____



Mark or comment on the above figure where you have your pain or problems.

Indicate on this line how bad your pain is—at the left end of line means no pain at all, at right end means worst pain possible.

Visual Analog Scale (VAS)

No Pain	(1) ____________________|____________________(10) (5)	Worst Possible Pain

For Internal Scoring Only

S	/ 33	**A**	/ 12	**VAS**	/ 10

Rev. 1/2017

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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:____

____

LIFE CHIROPRACTIC COLLEGE WEST

Intern:________________Doc#_______Patient:____________________File#___________Date___________

Review of Systems: Please check any conditions or symptoms that apply to you. (Current symptoms have been experienced within the past 6 months.) Please mark the box (☐) on the left side if had the condition in the past, and mark the box (☐) on the right if the symptom or condition is experienced currently.

Injuries/Trauma (list date next to injury):

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

Intern notes____

General History

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

Intern notes____

Eyes/Ear/Nose/Throat

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

Intern notes____

Lung/Respiratory

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

Intern notes____

Heart/Cardiovascular

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

Intern notes____

Stomach/Gastrointestinal

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

Intern notes____

Endocrine

P C Cold/heat intolerance
P C Diabetes
P C Excessive hunger/thirst
P C Hormone therapy
P C Unusual hair loss/growth
P C Voice changes

Intern notes____

Nervous System

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

Intern notes____

Urinary System

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

Intern notes____

Intern:______________________Doc#_______Patient:___________________File#__________Date________

Female History

P C Abnormal vaginal bleeding/discharge
P C Birth control/ method___________________________________
P C Hysterectomy
P C Irregular menstruation
P C Cramps/pelvic pain
P C Breast lump/pain
P C High Blood Pressure
P C Hormone therapy
P C Fibroids/ovarian cyst
P C Heavy menstrual bleeding

Concerns about your reproductive health:____

P C My menses are regular
P C I am pregnant
P C I am in menopause
P C I do have osteoporosis/penia
P C My menses are not regular
P C I am not currently pregnant
P C I am not currently in menopause
P C I do not have osteoporosis/penia

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

_____ Number of complicated pregnancies
_____ Number of terminated pregnancies
_____ Number of vaginal deliveries
_____ Number of uncomplicated pregnancies
_____ Number of C-sections
_____ Number of miscarriages

Intern notes ____

Male History

P C Burning/frequent urination
P C Erectile dysfunction
P C Hesitancy/dribbling
P C Prostate disease/BPH
P C Urine retention
P C Concerns about your reproductive health:____

Intern notes____

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

P C Alzheimers__________________________
P C Backache__________________________
P C Cancer __________________________
P C Depression__________________________
P C Dementia__________________________
P C Diabetes__________________________
P C Headache__________________________
P C Heart disease__________________________
P C Stroke__________________________
P C Tremors__________________________

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:____

Intern notes____

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

Medication/Vitamin Name	Quantity/dosage	How often	Why/When did you start taking?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			