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's Desire for Care Outcome(s):
Are you interested in anything in particular as a result of your care, If so, please list below.

1. ____
2. ____
3. ____

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:_________

Frequency __________________ Duration ___________________

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?**

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

Intern notes ____

General History

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

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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.				