Monte H. Greenawalt

LIFE WEST HEALTH CENTER

Chiropractic | Health | Wellness

Monte H. Greenawalt Health Center

New Patient Forms

This Packet is Current as of March 30, 2018

Monte H. Greenawalt

LIFE WEST HEALTH CENTER

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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.

Patient Information

Monte H. Greenawalt
LIFE WEST
HEALTH CENTER
Chiropractic | Health | Wellness

First Name_____Middle Name _____ Last Name_____

Sex ☐ M ☐ F Date of Birth (MM/DD/YYYY) _____SSN#_____

Address_____

City/State/Zip_____

Home Phone _____Mobile Phone _____Mobile Carrier_____

Email _____Preferred contact method ☐ Home ☐Cell ☐Work ☐ Email

☐Check here if you would like to opt out of receiving email or text appointment reminders or marketing newsletters

Occupation _____Business/Employer Name _____

Employer Address _____

City/State/Zip _____

Primary Care Doctor _____

Phone Number _____

Marital Status ☐ S ☐M ☐ W ☐ D ☐ P

Spouse/Partner Name _____Number of Children _____

Emergency Contact _____Phone Number _____

Payment is expected at the time of visit.

Person responsible for payment _____

Type of insurance ☐ Medicare Part B ☐Medi-Cal ☐ Both ☐None

Please complete the following:

Has an injury occured at work? ☐Yes ☐No

If so: Have you notified your employer? Yes☐ No☐Name of supervisor_____

Date and location of injury _____

Is your injury the result of a motor vehicle accident? ☐ Yes ☐ No Is there a police report? ☐ Yes ☐No

Do you have an attorney for this case? Yes ☐ No ☐

******Please bring all associated paperwork to your appointment******

How did you hear about the Life West Health Center?

☐ From a current intern/student. Name: _____

☐ From a patient. Name: _____

(We would like to properly thank this individual)

☐Internet ☐Browser search ☐ Facebook ☐ Yelp ☐Other, please specify:_____

☐ I am a relative of a student. Student's name_____Relationship_____

☐ Other _____

Patient/Guardian Signature_____Date_____

Privacy Notice

Monte H. Greenawalt
LIFE WEST
HEALTH CENTER
Chiropractic | Health | Wellness

25001 Industrial Blvd.
Hayward, CA 94545
Telephone (510) 780-4567

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Life Chiropractic College West is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Health Center. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Health Center by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Health Center authorized to remove the files from the Health Center's office.

NO CONSENT REQUIRED
The Health Center may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Health Center will provide your PHI to those health care professionals, whether on the Health Center's staff or not, directly involved in your care so that they may understand your health condition and needs.
(b) Your PHI will be reviewed by members of the College's faculty who are involved in the administration of patient care.
(c) Payment - In order to get paid for services provided to you, the Health Center will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
(d) Health Care Operations - In order for the Health Center to operate in accordance with applicable law and insurance requirements and in order for the Health Center to continue to provide quality and efficient care, it may be necessary for the Health Center to compile, use and/or disclose your PHI.

The Health Center may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Health Center obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Health Center in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Health Center attempts to obtain your Consent as soon as possible; or

- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Health Center has been unable to obtain your Consent and the Health Center determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Health Center is required by law to make such disclosure. If the Health Center is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Health Center may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Health Center may disclose your PHI if the Health Center believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Health Center may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Health Center may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Health Center is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Health Center may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Health Center may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Appointment Reminders
• Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
• You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

Sign-in Log
This Health Center maintains a sign-in log for individuals seeking care and treatment in the office. This sign-in sheet are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Health Center's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Health Center's offices.

Family/Friends
The Health Center may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Health Center to the contrary. The Health Center may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Health Center may use or disclose your PHI if you agree, or if the Health Center can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

- (b) If you are not present, the Health Center will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION
Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions
You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Health Center is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Health Center's Privacy Officer. In your written request, you must inform the Health Center of what information you want to limit, whether you want to limit the Health Center's use or disclosure, or both, and to whom you want the limits to apply. If the Health Center agrees to your request, the Health Center will comply with your request unless the information is needed in order to provide you with emergency treatment

You Have a Right to
Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Health Center's Privacy Officer. The Health Center can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Health Center's Privacy Officer. The Health Center will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Health Center upon request to the Health Center's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Health Center's Privacy Officer. You must provide a reason that supports your request. The Health Center may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Health Center (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Health Center, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Health Center's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Health Center

Complain to the Health Center or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Health Center, you must contact the Health Center's Compliance Officer, Dr. Michelle Massa, Life Chiropractic College West Health Center, 25001 Industrial Blvd., Hayward, CA 94545, (510) 780-4567. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Health Centers and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Health Centers. I understand that this form will be placed in my patient chart and maintained for six years.

HEALTH CENTER'S REQUIREMENTS

The Health Center:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Health Center's legal duties and privacy Health Centers with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

_____ _____ _____

Patient Name (Printed) Patient's Signature Date:

If you are a minor, or if you are being represented by another party

_____ _____ _____

Personal Representative (Printed) Personal Representative Signature Date

_____

Description of the authority to act on behalf of the patient

☐ I would like a copy of this notice

Receipt of Notice

Monte H. Greenawalt
LIFE WEST
HEALTH CENTER
Chiropractic | Health | Wellness

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
LIFE CHIROPRACTIC COLLEGE WEST HEALTH CENTER
25001 Industrial Blvd., Hayward, CA 94545
510-780-4567

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Life Chiropractic College West Health Center's "NOTICE OF PRIVACY PRACTICES."

As required by the Privacy Regulations, _____from
Name of Staff Member
Life Chiropractic College West Health Center has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that Life Chiropractic College West Health Center has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests: (Check only if you have a stated specific request, otherwise just sign/print name below)

☐ I wish to file a "Request for Restriction" of my Protected Health Information.

☐ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

☐ I wish to object to the following in the "Notice of Privacy Practices:"

_____

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

_____ _____
Signature Date

_____
Print Name

_____

(OFFICE USE ONLY)
Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____

_____

_____

If you have any further questions or comments, please feel free to contact our Compliance Officer Michelle Massa, D.C., 510-780-4500, ext 2570

Patient Authorization Form

Monte H. Greenawalt
LIFE WEST
HEALTH CENTER
Chiropractic | Health | Wellness

Patient File #: _____

25001 Industrial Blvd., Hayward, CA 94545,
510-780-4500, Fax: 510-780-4511

The Health Center at Life Chiropractic College West is a teaching facility, as such we utilize an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients, staff, interns and/or faculty. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting that may or may not involve direct faculty oversight and participation. Further the nature of a teaching clinic involves the participation of faculty, interns and staff in a team approach to your evaluation and care, therefore your patient records may be reviewed by members of the College's faculty who are involved in the administration of patient care at the Health Center. The use of these circumstances is intended to make your experience with the College's Health Center more efficient and productive as well as to enhance your access to quality health care and health information.

We are requesting an authorization of you acknowledging and agreeing to care in the circumstances outlined above. Your authorization is sought due to various interpretations under federal law with respect to your rights to privacy.

Your signature indicates your acceptance of and agreement with this authorization.

_____	_____	_____
Patient Name (printed)	Signature	Date

Additionally as a teaching institution the Health Center at Life Chiropractic College serves as an important resource for teaching clinical management skills to our students. As a patient in our Health Center we are asking for your permission to use your patient records as a teaching tool. We assure you that all information such as your name, address, Social Security number and other identifying information will be removed for your privacy and protection. If you choose not to provide the College and the Health Center with your authorization your decision will have no adverse effect on your care or on your relationship with our staff.

Your signature indicates your acceptance of and agreement with this authorization.

_____	_____	_____
Patient Name (printed)	Signature	Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Your care in our facility will not be conditioned on you agreeing to these authorizations. A revocation of your authorization regarding any or all of the elements outlined above should be addressed to our Privacy Officer Michelle Massa, D.C.

Information that we use or disclose based upon this authorization may be subject to re-disclosure by anyone who has access to the information and may no longer be protected by the federal privacy rules.

This notice is effective as of October 1, 2004. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Patient Information Release

Monte H. Greenawalt
LIFE WEST
HEALTH CENTER
Chiropractic | Health | Wellness

Patient File #: _____

I,_____, hereby authorize Life Chiropractic College West (LCCW) Health Center and their authorized representatives (student interns, faculty members, Radiologists, etc.) to inspect, copy or otherwise reproduce, as they see fit, any and all records pertaining to my case as a patient of the LCCW Health Center.

It is understood and agreed that the amount paid to the Health Center for x-rays is for examination and interpretation only and the x-rays themselves will remain the property of this facility. They will remain on file where they may be reviewed at any time as long as I am a patient here.

I further understand that this is a teaching and training institution. In this regard, I authorize my case and all records pertaining to it to be used for that purpose.

_____
Patient Name (Parent name if patient a minor)

_____ _____
Patient Signature (Parent signature if patient a minor) Date

_____
Life West Health Center Staff

Cash Patients

Monte H. Greenawalt
LIFE WEST
HEALTH CENTER
Chiropractic | Health | Wellness

Patient File #: _____

Welcome to the Life Chiropractic College West Health Center. We are pleased to provide quality services to you at substantial savings. You will be provided quality Chiropractic care at the following rates:

SERVICES	**FEES**
Initial Examination	$65.00
Office Visit	$30.00
Office Visit/NO Adjustment	$30.00
Re-evaluation Examination	$30.00
Re-evaluation AND Adjustment	$45.00
Ancillary Procedures	$10.00
X-Rays (if necessary)	$40.00 - $120.00 per series
Reactivation (One year or more since last visit)	$65.00
Missed Appointment/Non-Cancellation Fee	$10.00 per appointment

Laboratory Fees: Lab Corp Laboratories provides all services, billing, and collections. See Receptionist for additional information on services and fees. Initial: _____

Missed Appointment/Non-Cancellation Fee: (unless a prior 24-Hour notification has been made by patient) As a courtesy, we ask that our patients provide an advance notification, if this advanced notice is not received, we will access a $10.00 missed appointment/non-cancellation fee to your account. Initial: _____

Payment for services must be made on the day the service(s) are provided. Initial: _____

With my signature below, I hereby acknowledge receipt of the Health Center Fee Schedule and I agree with the Health Center financial policies.

_____
Patient Name (Parent name if patient a minor)

_____ _____
Patient Signature (Parent signature if patient a minor) Date

_____
Life Chiropractic College Health Center Staff

Welcome Letter

Monte H. Greenawalt
LIFE WEST
HEALTH CENTER
Chiropractic | Health | Wellness

Life Chiropractic College West Health Center
25001 Industrial Blvd, Hayward, CA. 94545
Phone: (510) 780-4567

Welcome to the Life West Health Center. We provide high quality healthcare by caring for your spine and nervous system through non-invasive, conservative means. Children are welcome in our facility, as both patients and guests. However, they must by supervised by a parent at all times.

We have orientation talks for all new patients. They are extremely important because they inform you as to the value of chiropractic and what to expect as you begin your care with our facility. Please speak to your intern regarding attendance.

Fees - Physical examinations $65, office visits $30, and Missed appointment/Non-cancellation $10.00. A full fee schedule will be given to patients as part of their new patient paperwork. Absolutely no refunds can be used once an intern begins the case history!

Paperwork - On your first visit, you will be requested to fill out a form that includes your name, address, biographical data, as well as your billing information. Please bring a picture ID, all insurance cards, and be prepared to make a payment for all services at the time of visit. You will be given a copy of the fee schedule to sign, as well as federal notices of privacy and practices. Paperwork takes approximately 30 minutes to complete.

Intern assignment - If you made an appointment in advance, an intern will be assigned to you after your paperwork is completed.

Patient case history - During your first visit, your intern will conduct a thorough case history that will help us determine your health care needs. This history will include questions about your current health, your fam-ily history, and prior health care you may have received. After your case history is complete, it will be reviewed by one of our licensed faculty doctors. As a learning institution our interns are under the direct supervision of experienced doctors of chiropractic. All patient histories, examinations, x-rays and ongoing patient care visits are closely reviewed and authorized by our licensed faculty doctors to ensure your safety and the most appropriate care for your condition.

Physical examination - The next step is a thorough orthopedic, neurological, and Chiropractic physical examination. After completing the examination, your intern will review the exam results with a faculty doctor. X-rays, laboratory tests, or other diagnostic studies may be required as part of your examination. If x-rays or additional tests are necessary, you will work with your intern to schedule an appointment for these tests.

X-rays may be used to help detect problems or other conditions that can't be identified through the physical examination or case history alone. Only necessary x-rays are taken. We also use the most up-to-date equipment, including state-of-the-art digital x-ray technology for patient safety.

After the diagnostic procedures are complete, the intern prepares a narrative case report, which includes what was found during the physical examination, history, and x-rays. This narrative report is reviewed by a faculty doctor, who then works with your intern to determine the appropriate course of care for your condition. Based on the case and your individual needs, the faculty reviews your care plan every 6-12 weeks.

Once a faculty member has reviewed and approved your care, your intern gives a report of findings. This includes the type of care he or she plans to administer, how often you will be seen, and for how long. At this time you will also receive your first chiropractic adjustment. After your first adjustment, your subsequent visits will be scheduled based on the care your intern has recommended and was approved by our faculty.

Re-evaluation examination - After you have received a period of care generally between one-and-a half to two months – your intern will conduct a re-evaluation examination to determine your progress. Your intern will work with faculty members to determine the best course of care for you. Occasionally, patients are referred to another health-care provider for consultation. In most cases you can continue your chiropractic care while we obtain the additional information from these providers.

Inactive Status - If you suspend care for a year or more, your file will be made inactive. A reactivation exam fee of $65.00 will be required to resume care.

As a learning institution, we hope and expect you will enter into a "working relationship" with us. In return for your time and patience, we are extending a reduced fee for visits while providing excellent detailed service as our interns become trained doctors of chiropractic. We thank you in advance for your understanding that procedures will take longer than if you were in a private doctor's office.

Welcome to the Health Center and we wish you good health through chiropractic.

Print Name_____

Signature_____

Date_____

Monte H. Greenawalt
LIFE WEST
HEALTH CENTER
Chiropractic | Health | Wellness

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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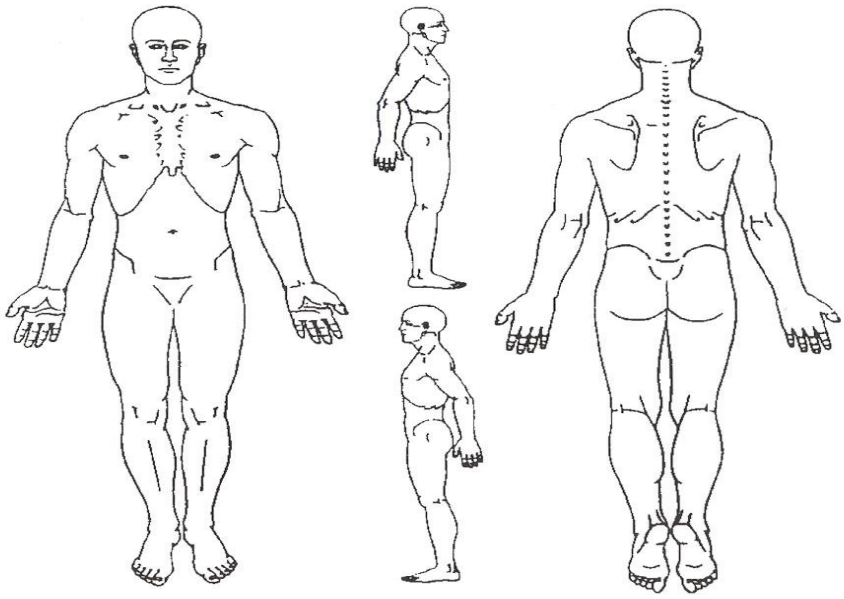
PATIENT SURVEY

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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LIFE WEST
HEALTH CENTER
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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? ☐ Yes ☐ No

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:_____

Monte H. Greenawalt
LIFE WEST
HEALTH CENTER
Chiropractic | Health | Wellness

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.				