LIFECARE
CHIROPRACTIC

PATIENT INFORMATION:

First Name:_____ Middle Initial:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Email Address:_____

Home Phone: (___) ____-_____ Work Phone: (___) ____-_____ Cell Phone: (___) ____-_____
Emergency Phone: (____) ____-_____

Date of Birth: _____ Social Security #: _____ Sex: M_____ F_____

Marital Status:_____ Spouse's Name:_____ Children # :_____

Person Responsible for Payment: _____

EMPLOYER INFORMATION

Please Check One: Patient's Employer_____ Responsible Party's Employer _____

Employer Name:_____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

Please indicate how you heard about our clinic and tell us the name of your source:

( ) Referring Physician:_____ ( ) Patient:_____
( ) Newspaper:_____ ( ) Phone Directory:_____
( ) Student:_____ ( ) Health Screen – Location_____
( ) Drove by Clinic:_____ ( ) Other:_____

I understand and agree that I am financially responsible for the services that I receive from Lifecare Chiropractic, Inc ("Lifecare Chiropractic "). If a person is designated above as "Person Responsible for Payment," such person may also be responsible for payment, but that designation does not affect my agreement to pay for the services that I receive from Lifecare Chiropractic. If I fail to pay for the services that I receive from Lifecare Chiropractic within 30 days, I expressly agree to pay all costs of collection, including, but not limited to attorneys' fees and taxable and non-taxable costs. I agree to pay for the services that I receive from Lifecare Chiropractic in the following manner:

Cash_____ Check_____ Visa_____ Mastercard_____

Also, I hereby authorize the physician to diagnose and treat me (or my dependent/minor child), and to take those x-rays that are clinically indicated.

Patient's Signature:_____ Date:_____
(or Patient's Parent/Guardian, if Minor)

Patient # : _____

Patient Health Questionnaire

Patient Name _____ ***Date*** _____

File number _____

1) Describe your symptoms: _____

_____

_____

2) When did your symptoms begin? _____

3) How did your symptoms begin? _____

_____

4) What makes your symptoms worse (activities, positions, etc…)? _____

_____

5) What makes your symptoms better (activities, positions, medications, etc…)? _____

_____

6) How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Intermittently (26-50% of the day)
- Occasionally (0-25% of the day)

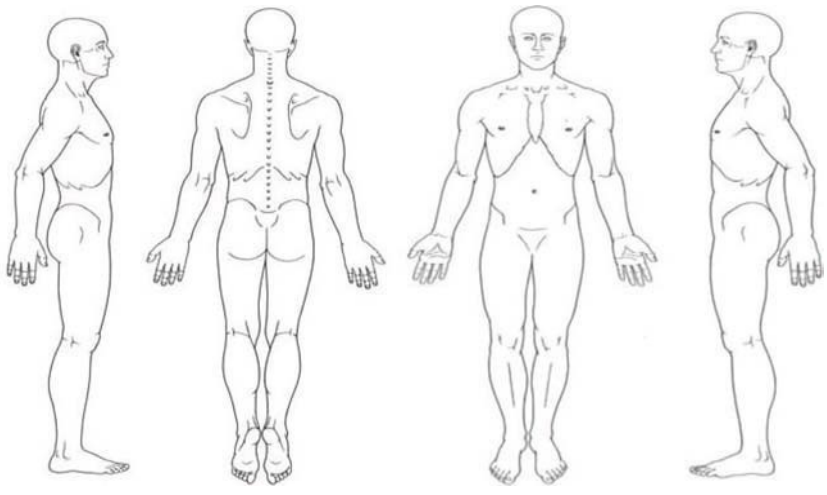
7) What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling

9) How are your symptoms changing?

- Getting better
- Staying the same
- Getting worse

8) Indicate where you have pain or other symptoms below



9) Please mark an "X" at the position on the scale to indicate how much pain you feel at this time for each location of pain you are experiencing:

no pain_____worst pain imaginable

Location:

no pain_____worst pain imaginable

Location:

no pain_____worst pain imaginable

Location:

10) How much has pain interfered w/ normal work (work both inside or outside the home)

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

11) During the past 4 weeks, how much of the time has your condition interfered with your social activities such as visiting with friends, hobbies, exercise?

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

12) In general, how would you currently rate your overall health?

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

13) Who have you seen for your symptoms? ○ No one ○ Medical doctor ○ Chiropractor ○ Physical Therapist ○ Other

a) What treatment did you receive and when? _____

_____

b) What tests have you had performed and approx when? ○ MRI _____ ○ CT scan_____ ○ X rays_____ ○ Blood work_____ ○ Other_____

14) Have you had similar symptoms in the past? ○ Yes ○ No

a) If you have received treatment for similar symptoms in the past, what kind of provider did you see?

○ This office ○ Chiropractor ○ Medical doctor ○ Physical Therapist ○ Massage Therapist ○ Other

Patient Signature _____ Date _____

CONFIDENTIAL HEALTH HISTORY **Pt Name:_____**
Pt File No:_____

The items below may relate to your current condition. Please place a check in the column if you are currently troubled or if you have ever had a particular symptom.

General
☐01 Abnormal weight loss/gain
☐02 Alcoholism/drug abuse
☐03 Allergies
☐04 Blood/bleeding problems
☐05 Breast lumps/soreness
☐06 Cancer
☐07 Depression/anxiety
☐08 Diabetes
☐09 Excessive thirst
☐10 Fever/chills without flu)
☐11 General fatigue
☐12 Night sweats
☐13 Poor sleep
☐14 Thyroid disease/goiter

Gastrointestinal
☐15 Abdominal pain
☐ 16 Appendicitis
☐ 17 Belching/gas
☐ 18 Black//bloody stools
☐ 19 Constipation
☐ 20 Diarrhea
☐
☐22 Gallbladder problems
☐23 Hemorrhoids
☐24 Hernia
☐25 Liver problems/jaundice
☐26 Frequent nausea/vomiting
☐27 Pain over abdomen
☐28 Poor appetite
☐29 Poor Digestion
☐30 Ulcer/heartburn

Eye, Ear, Nose and Throat
☐31 Deafness/ difficulty hearing
☐32 Dental problems
☐33 Ear noises/ringing
☐34 Hoarseness
☐35 Nosebleeds
☐36 Nose problems
☐37 Pain in/behind eyes
☐38 Sinus problems/hay fever
☐ 39 TMJ/other jaw pain
☐40 Tonsillectomy
☐41 Visual disturbances

Cardio-Respiratory
☐ 42 Ankle swelling
☐43 Asthma/wheezing
☐ 44 Chest pains
☐ 45 Chronic cough
☐46 Difficulty breathing
☐47 Emphysema
☐48 High blood pressure
☐49 High cholesterol levels
☐50 Irregular heartbeat
☐51 Previous heart trouble
☐52 Rheumatic fever
☐ 53 Spitting phlegm/blood
☐54 Stroke
☐55 Tuberculosis
☐56 Varicose veins

Skin
☐ 57 Bruising easily
☐ 58 Change in mole(s)
☐59 Itching/eczema/rash
☐ 60 Skin cancer

Genitourinary
☐61 Blood in urine
☐62 Difficulty starting flow
☐63 Frequent urination
☐64 Frequent night urination
☐65 Inability to control flow
☐66 Kidney disease/stones
☐67 Painful urination
☐68 Sexual difficulties
☐69 Urinary tract infection
☐70 Venereal infection

Women Only
☐71 Endometriosis
☐72 Excessive flow
☐73 Irregular cycles
☐74 Hot Flashes
☐75 Painful periods
☐76 PMS
☐77 Pregnancy - # of births__
☐78 Vaginal burning/itching
☐79 Date last period began
_____
☐80 Date of last PAP Test
_____

Men Only
☐ 81 Testicular swelling/pain
☐82 Prostate problems

Neurological
☐83 Convulsions
☐84 Dizziness
☐ 85 Fainting
☐86 Headache
☐87 Mental disorder
☐88 Numbness/tingling
☐89 Twitching/tremors/epilepsy
☐90 Weakness

Musculoskeletal
☐91 Neck stiffness/pain
☐92 Pain between shoulders
☐93 Low back pain
☐94 Hip/knee/ankle/foot pain
☐95 Osteoporosis
☐96 Rheumatoid arthritis
☐97 Shoulder/elbow/wrist/hand Pain
☐98 Scoliosis

Habits
☐99 Smoking packs/day
☐100 Drinking
☐101 Exercise days/week
☐102 Recreational drug use

Family History
(brothers, sisters, parents, grandparents only, not yourself)
☐103 Cancer
☐104 Diabetes
☐105 High blood pressure
☐106 Heart disease/stroke
☐107 Kidney disease
☐108 Muscle, bone, nerve disease
☐109 Thyroid disease

Height::_____
Weight::_____

Lifecare Chiropractic

1830 S. Alma School Rd #135 • Mesa, AZ 85210
Phone (480) 839-2273 • www.lifecarechiro.com

Are you healthier now then you were 5 years ago? Y N

If yes, what have you done to improve your health?

Do you expect that you will be healthier in 5 years? Y N

If yes, what will you do to achieve this goal?

If no, what do you think you could do better?

Many patients that come into our office either have a chronic disease (high cholesterol, osteoporosis, diabetes, heart disease, high blood pressure, etc.,) or have a family history that has concerned them (Alzheimer's, cancer, diabetes, Parkinson's, etc…).

Both Dr. Bogash and Dr. Arlt are very knowledgeable in guiding patients towards healthier lifestyles as well as powerful supplements that may help lower your risk of chronic disease. Lifestyle changes are the best answer to chronic disease, but they require a much greater investment on the part of the patient. We understand that not every patient is willing to make this type of involvement at this time. In order for us to meet you where you are at, please circle which category you fall into.

A) I am interested and willing to make lifestyle changes (diet, exercise, stress management) to improve my health and lower my risk.

B) I'm not that excited about lifestyle changes. I am however, interested in purchasing supplements that can help improve my health and lower my risk of serious disease. I understand that this is NOT the optimal way, but I want to do something to improve my health status.

C) At this time, I have no interest in either supplements or lifestyle changes to improve my health.

Patient Name: _____

File Number: _____

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ERISA ASSIGNMENT FORM

I assign the right to payment for all medical benefits directly to James Bogash, DC or Kristen Arlt, DC in consideration for medical services and supplies provided pursuant to my health insurance plan.

In the event my health insurance plan refuses to pay for provided, medically necessary services, I also assign all my ERISA* rights to James Bogash, DC or Kristen Arlt, DC for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for faulty claims processing. This ERISA assignment is in consideration for the unpaid services provided, in consideration for my insurance plan's reduced fee schedule, and in consideration for the continued willingness of James Bogash, DC or Kristen Arlt, DC to see patients, including myself, on an insurance assignment basis. I understand that if my treating doctor prevails in any such payment dispute, I may be liable for co-payment for the contested services.

I give consent to release medical information to James Bogash, DC or Kristen Arlt, DC. I give consent to James Bogash, DC or Kristen Arlt, DC to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to James Bogash, DC or Kristen Arlt, DC to send medical information, as necessary, to my insurance plan.

*ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts up to $110 a day for each infraction.

Patient's printed name _____

Patient's signature_____ Date_____