LIFE University

Patient General Information Questionnaire

College of Chiropractic Clinic System

We, the clinic faculty and staff, are committed to serve our community in a professional clinical environment and to empower patients to actively participate in their healthcare. The Life University Clinics recognize and respect the self-aware, self-directed, self-maintaining, self-healing, and self-improving nature of life and living beings.

If you have been involved in an auto accident or a work injury please speak to one of the office assistants before completing this form.

This section is to be completed by the Staff.
Date: ________________ Faculty Clinician: ________________________________ No. __________

Intern Name: ____ Intern No. ______________

SECTION 1

Personal Data

Patient Name: First _____________________ Last ______________________________ M.I. _______

Prefers to be called _____________________ Birth Date ____/____/_______ ☐ M ☐ F

Parent or Guardian's Name if the Patient is a Minor: ____

Are you currently pregnant? ☐ Yes ☐ No ☐ Maybe. Have you ever been pregnant? ☐ Yes ☐ No

Home Address: ____

City: ______________________________________ State: __________________ Zip: _______________

Phone: Home:___________________ Work: ____________________ Mobile: __________________

E-mail: ____

Current Employer_____________________________________ Contact Phone: __________________

Work Address: ____

City: ______________________________________ State: __________________ Zip: _______________

Job Description ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse/Partner Name: ________________________ Spouse's Employer: _______________________

Number of Children: __________________________ Ages: __________________________________

Emergency Contact Person: ________________________________ Phone : _____________________

SECTION 2

Reason for Care: I am here for a Specific Condition Yes ☐ No ☐ *If **No** please go directly to SECTION 3*

Primary Complaint	Secondary Complaint	Tertiary Complaint
Briefly describe complaint: ______________________________ ______________________________ ______________________________	Briefly describe complaint : ______________________________ ______________________________ ______________________________	Briefly describe complaint : ______________________________ ______________________________ ______________________________
PAIN SCALE (CIRCLE) BEST WORST 0 1 2 3 4 5 6 7 8 9 10	PAIN SCALE (CIRCLE) BEST WORST 0 1 2 3 4 5 6 7 8 9 10	PAIN SCALE (CIRCLE) BEST WORST 0 1 2 3 4 5 6 7 8 9 10
Is it constant? ☐ Yes ☐ No Comes & goes? ☐ Yes ☐ No Please check ALL that describe your current symptoms? ☐ Sharp ☐ Pins/Needles ☐ Stabbing ☐ Tingling ☐ Dull ☐ Numbness ☐ Aching ☐ Tightness ☐ Pinching ☐ Other Please check ALL that aggravate your condition? ☐ Driving ☐ Breathing ☐ Walking ☐ Coughing ☐ Sitting ☐ Sleeping ☐ Bending ☐ Working ☐ Standing ☐ Exercising ☐ Bowel Movements ☐ Other What makes your condition better? ☐ Chiropractic ☐ Stretching ☐ Rest ☐ Massage ☐ Recumbent ☐ Medication ☐ Sitting ☐ Nothing ☐ Standing ☐ Other Have you had this current complaint in the past? ☐ Yes ☐ No If Yes, when? ____/ ____/ ________ Have you seen any other healthcare providers for your current complaint? ☐ Yes ☐ No	Is it constant? ☐ Yes ☐ No Comes & goes? ☐ Yes ☐ No Please check ALL that describe your current symptoms? ☐ Sharp ☐ Pins/Needles ☐ Stabbing ☐ Tingling ☐ Dull ☐ Numbness ☐ Aching ☐ Tightness ☐ Pinching ☐ Other Please check ALL that aggravate your condition? ☐ Driving ☐ Breathing ☐ Walking ☐ Coughing ☐ Sitting ☐ Sleeping ☐ Bending ☐ Working ☐ Standing ☐ Exercising ☐ Bowel Movements ☐ Other What makes your condition better? ☐ Chiropractic ☐ Stretching ☐ Rest ☐ Massage ☐ Recumbent ☐ Medication ☐ Sitting ☐ Nothing ☐ Standing ☐ Other Have you had this current complaint in the past? ☐ Yes ☐ No If Yes, when? ____/ ____/ ________ Have you seen any other healthcare providers for your current complaint? ☐ Yes ☐ No	Is it constant? ☐ Yes ☐ No Comes & goes? ☐ Yes ☐ No Please check ALL that describe your current symptoms? ☐ Sharp ☐ Pins/Needles ☐ Stabbing ☐ Tingling ☐ Dull ☐ Numbness ☐ Aching ☐ Tightness ☐ Pinching ☐ Other Please check ALL that aggravate your condition? ☐ Driving ☐ Breathing ☐ Walking ☐ Coughing ☐ Sitting ☐ Sleeping ☐ Bending ☐ Working ☐ Standing ☐ Exercising ☐ Bowel Movements ☐ Other What makes your condition better? ☐ Chiropractic ☐ Stretching ☐ Rest ☐ Massage ☐ Recumbent ☐ Medication ☐ Sitting ☐ Nothing ☐ Standing ☐ Other Have you had this current complaint in the past? ☐ Yes ☐ No If Yes, when? ____/ ____/ ________ Have you seen any other healthcare providers for your current complaint? ☐ Yes ☐ No

Patient General Information Questionnaire

Patient Name: ______________________ **Date:** ____________ **File #:** __________

SECTION 3

Health Habits & Lifestyle

Please answer the questions below.

EXERCISE	DIET	ALCOHOL/TOBACCO/RECREATIONAL DRUG USE?
Do you exercise? ☐ Yes ☐ No How often do you exercise? ___ days/week ___ Hours/day Stretching / Flexibility ☐ Yes ☐ No Running / Treadmill/ Walking ☐ Yes ☐ No Rowing / Swimming ☐ Yes ☐ No Competitive Athlete ☐ Yes ☐ No Pilates /Yoga ☐ Yes ☐ No Group Exercise ☐ Yes ☐ No Weight Lifting ☐ Yes ☐ No	Do you have a healthy diet? ☐ Yes ☐ No How many serving s of fruits & vegetables per day? # ______ How many 8oz. glasses of water per day? # ________ Do you drink caffeinated beverages? ☐ Yes ☐ No How many per day? # _______ Please List Food Allergies? __________________________ __________________________ Have you ever had an eating disorder? ☐ Yes ☐ No	Do you use any of the above? ☐ Yes ☐ No How many cigarettes do you smoke? _______ /day or _______/wk Do you use smokeless tobacco? ☐ Yes ☐ No How much do you use a day? Cans or pouches _______ /day Do you have history of alcohol use? ☐ Yes ☐ No # drinks ____ /day _____ /wk 1 "drink" is equal to 12 oz. can of beer, 1.5 oz. liquor, 80 proof, 5 oz. wine.
OTHER: Please list- __________________________ __________________________ __________________________	**DAILY STRESS LEVEL SCALE** Low High 0 1 2 3 4 5 6 7 8 9 10 Have you ever sought help for a mental health issue? ☐ Yes ☐ No	**SLEEPING PATTERN** Hours of sleep per night? ______ hours Please circle appropriate sleep quality. Excellent Good Fair Poor Sleep interrupted _______ X/ night How long? ___ wks, ___ months, ___ years

SECTION 4

Personal Health History

*Please mark **all** issues below that you have currently or have had in the past.*

C = current P = past If **none** of the below apply please check this box ☐

MUSCLE /JOINT C P	EYES/EARS/THROAT C P	SKIN C P	CARDIOVASCULAR C P	GENERAL C P
Arthritis C P	Thyroid C P	Easy Bruising C P	Blood Pressure C P	Food Allergy C P
Back Pain C P	Hearing Difficulty C P	Psoriasis/ Eczema C P	Irregular Heart Beat C P	Dizziness C P
Sciatic Pain C P	Vision C P	Hives C P	Poor Circulation C P	Infections C P
Bursitis C P	DIGESTIVE C P	Skin Allergy C P	URINARY C P	INFECTIOUS DISEASES C P
Hip Pain C P	Stomach C P	Itching C P	Kidney C P	HIV C P
Foot Pain C P	Intestinal C P	Varicose C P	Difficulty Urinating C P	Hepatitis C P
Neck Pain C P	Colon C P	PULMONARY C P	REPRODUCTIVE C P	Tuberculosis C P
Headache C P	INTERNAL C P	Difficulty Breathing C P	Menstrual C P	ENDOCRINE C P
Shoulder Pain C P	Liver C P	COPD C P	Pregnancy C P	NEUROLOGICAL C P
Arm Pain C P	Gall bladder C P	Asthma C P	Prostate C P	PSYCHOLOGICAL C P
Wrist Pain C P	Pancreas C P	Seasonal Allergy C P	Venereal Disease C P	

Please list all the medications you are taking including over the counter medications, herbs & vitamins and nutritional supplements. *If none please write:* ***None***

Name / Dose / Frequency	Name / Dose / Frequency

Medication Allergies - Please list all below____

____

SECTION 5

Please list ALL accidents, injuries, surgeries & hospitalizations. *If none please write:* ***None***

Accidents, Injuries, Fractures (Dates) ____

____

Surgeries (Dates**)** ____

____

Hospitalizations (Dates) ____

____

Please list all your doctors and healthcare providers including previous Chiropractors

Name: ________________________________ Phone # ____________________

Name: ________________________________ Phone # ____________________

Name: ________________________________ Phone # ____________________

SECTION 6

Family History Please mark the appropriate box with an X. If **none** of the below please check this box ☐

HISTORY	Mother	Father	Brother/Sister	Grandmother	Grandfather
Diabetes	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Auto immune Disorder	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

Patient Name: ______________________________ **Date:** ______________ **File #:** ___________

1. Are you an employee, or related to an employee at Life University? ❑ Yes ❑ No Relationship: ___________
2. Are you a student, or related to a student in any program at Life University? ❑ Yes ❑ No Relationship: ___________
3. Are you a student, or related to a student in a DC Program? ❑ Yes ❑ No Relationship: ___________
4. Do you or a relative plan to enroll as a student in a Doctor of Chiropractic Program? ❑ Yes ❑ No
   If yes, When: __________________ and Relationship: ______________________________________
5. If you answered yes to 2, 3 or 4: Student's Name: ______________________________ Student ID: ___________

Consent for Chiropractic Care in Life University Clinics

Chiropractic care is based on clinical evidence of vertebral subluxations and not the presence or absence of pain, abnormal range of motion, or abnormal spinal curves. By the use of specific analysis and spinal adjustments, the goal of chiropractic is primarily to reduce/correct spinal subluxations.

- The Life University chiropractic clinics are teaching clinics.
- The chiropractic assessment and chiropractic care provided in the Life Clinics may occur in an open environment.
- In some situations, your care will occur in an open environment and personal health information (PHI) may be subject to incidental exposure by others in the clinic setting
- I understand that my records and/or x-rays are the property of Life University and will be used for teaching and research purposes and if at anytime I request a copy of my records and/or x-rays there will be an additional charge for copying them.
- I authorize Life Clinics and its agents to administer care as needed, as indicated from examination findings.
- I authorize Life Clinics to release information to my doctor and/or insurance company.
- I understand that if I am in litigation for any accident my settlement may be jeopardized by the fact that a student is rendering my care in this clinic.
- A parent or an approved individual MUST accompany their minor child on every visit to the clinic.
- I acknowledge that I have read Life University's Notice of Privacy Practices (or had the opportunity to read it if I so choose). I have received a summary of Life University's Notice of Privacy Practices and acknowledge that I may have a personal copy of the entire Notice upon request.
- I consent to the use and or disclosure of my protected health information as specified in Life University's Notice of Privacy Practices.

I have read and understand the above.

______________________________________ ____________________ __________

Patient Signature Relationship to Patient Date
(custodial parent or legal guardian if patient is a minor)

______________ ________ ______________ ______________ __________

Witness Signature Date Print Clinician Name - # Faculty Clinician Signature Date

Health is affected by your nervous system, but it is also affected by your environment, the foods you eat, and your lifestyle activities and habits.

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Administration Only

PATIENT CATEGORY					
☐	R	Regular	☐	I	Insurance
☐	T	Transient	☐	TS	Transient DC Student
☐	C	Child	☐	E	Veteran
☐	P	Employee	☐	O	Employee Family
☐	G	Gratis	☐	G1	Partial Gratis
☐	GA	Alumni	☐	GF	Alumni Family
☐	LS	LU Student	☐	LF	LU Student Family
☐	GM	Medicare	☐	NS	College Students
☐			☐	EM	Active Military
☐	S	DC Student	☐	F	DC Student Family

How did you hear about us?

- ☐ Website
- ☐ Friend / Family member Name: ____________________
- ☐ Intern Name: ____________________
- ☐ Life Center for seniors Name: ____________________
- ☐ Health Fair Name: ____________________
- ☐ Other Name: ____________________

PHOTO ID

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