

LifeLong Health & Wellness Center
Chiropractic Associates, PC
5540 South St. Ste. 200 Lincoln, NE 68506 402-488-1500

PATIENT INFORMATION

Patient Last Name: _____ M.I.: _____ First Name: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell #: _____ Social Security _____
E-Mail Address: _____ Drivers License #: _____
Birth Date: _____ Age: _____ Marital Status S ___ M ___ D ___ W ___ Sep ___
Employer: _____ FT ___ PT ___ Employer Phone: _____

POLICY HOLDER INFORMATION

Relationship to Patient: Parent ___ Child ___ Spouse ___ Birth Date: _____
Last Name: _____ First Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell #: _____ E-Mail: _____
Employer: _____ Employer Phone: _____
Social Security Number: _____
Emergency Contact Not Living With You
Name: _____ Relationship: _____ Phone #: _____
Address: _____ Cell #: _____

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Have you or are you considering applying for Medicaid? Y _____ N _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby confirm that all the information provided by me is accurate. Any false information will result in my responsibility for any costs incurred due to fraudulent information. I authorize release of any medical or other information necessary to process my insurance claim.

Signature _____ Date _____

AUTHORIZATION OF PAYMENT: I realize that any insurance that I have is a contract between myself and that company. I authorize all insurance benefits to the Physician for services performed. I am responsible for providing the insurance information for the submission of claims. I am also responsible for any non-covered services or for services for which no referral was obtained.

Signature _____ Date _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I have had the opportunity to obtain a copy of Chiropractic Associates, P.C./LifeLong Health and Wellness (medical practice) Notice of Privacy Practices for Protected Health Information. I have been informed that I may have a copy of this notice at anytime. I have been informed that the Medical Practice has available to me a copy of the Notice of Privacy Practices for Protected Health Information posted in the waiting room for my use.

Signature _____ Date _____

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FINANCIAL POLICY

Commercial Insurance

As a courtesy to our patients that have insurance covering chiropractic care we submit to that carrier at no charge. For the portion of the care your insurance will pay for we agree to wait for that payment. We submit to one insurance company per patient.

The portion not covered by your insurance is your responsibility.

We ask that your portion of your bill be paid at the time of service. In the event of an overpayment and a credit exists on your account, Lifelong Health & Wellness Center/Chiropractic Associates, PC will issue the insured a check in the amount of that credit.

All supplies (supports, braces, pillows, vitamins...etc.) must be paid for when taken. If you request we will bill these items to your insurance, however, the majority of insurance carriers do not cover these items so we ask they be paid for up front.

We accept cash, credit card, and personal checks. A \$25 charge will be assessed on all returned checks.

I _____ understand that although I have assigned insurance benefits to this office it is likely and probable that my insurance coverage will be less than the amount billed. I acknowledge that it is my responsibility to pay the balance of my bill during care once my benefits have been received.

Signed: _____ Date: _____

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Confidential Patient Health Record

Patient Name : _____

Today's Date: ____/____/____

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Yellow pages Drove by Hospital Insurance Plan

Personal Information

CURRENT HEALTH CONDITION

Chief complaint (Why you are here today): _____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

When did this condition begin? ____/____/____

Has it ever occurred before? Yes No
 When? _____

Is the condition: Auto Related Work Related
 No Injury Other

Explain: _____

Date of Accident: _____

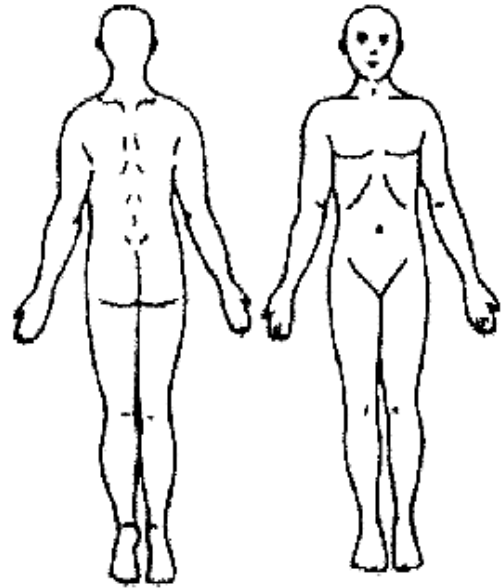
Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work Related:

Have you filed an injury report with your employer? Yes No

Claim #: _____



Use the letters below to indicate the type and location of your sensations right now:
 A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing O=Other

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care. Have you had the following symptoms or problems either in the past or now? Please check the appropriate boxes.

General: I DENY having or have had any of the symptoms or problems listed below.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> chills | <input type="checkbox"/> fatigue | <input type="checkbox"/> night sweats | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> rashes | <input type="checkbox"/> unusual lymph glands or lumps |
| <input type="checkbox"/> daytime drowsiness | <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> risk factors for AIDS | |

Eyes/Vision: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> blindness | <input type="checkbox"/> change in vision | <input type="checkbox"/> field cuts | <input type="checkbox"/> photophobia |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> double vision | <input type="checkbox"/> glaucoma | <input type="checkbox"/> tearing |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> eye pain | <input type="checkbox"/> itching | <input type="checkbox"/> wear glasses/contacts |

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Ears, Nose and Throat: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> bleeding | <input type="checkbox"/> ear drainage | <input type="checkbox"/> hearing loss | <input type="checkbox"/> nosebleeds | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> dentures | <input type="checkbox"/> ear pain | <input type="checkbox"/> history of head injury | <input type="checkbox"/> postnasal drip | <input type="checkbox"/> nasal congestion |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> fainting | <input type="checkbox"/> hoarseness | <input type="checkbox"/> snoring | <input type="checkbox"/> TMJ problems |
| <input type="checkbox"/> discharge | <input type="checkbox"/> frequent sore throats | <input type="checkbox"/> loss of sense of smell | <input type="checkbox"/> sinus infections | <input type="checkbox"/> headaches |
| <input type="checkbox"/> tinnitus
(ringing in ears) | <input type="checkbox"/> difficulty
swallowing | <input type="checkbox"/> rhinorrhea
(runny nose) | <input type="checkbox"/> bleeding gums | <input type="checkbox"/> migraines |

Respiration: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---------------------------------|--|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> coughing up blood | <input type="checkbox"/> sputum production | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> cough | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing | <input type="checkbox"/> recurrent pneumonia or bronchitis |

Cardiovascular: I DENY having any of the symptoms or problems listed below.

- | | | |
|---|---|---|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> bruise or bleed easily |
| <input type="checkbox"/> claudication (leg-calf pain/ache) | <input type="checkbox"/> swelling of legs | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> palpitations | <input type="checkbox"/> heart failure |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> racing heart | <input type="checkbox"/> blood transfusion |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> orthopnea (difficulty breathing lying down) | <input type="checkbox"/> blood clotting |
| <input type="checkbox"/> shortness of breath
with exertion or exercise | <input type="checkbox"/> paroxysmal nocturnal dyspnea
(waking at night w/ shortness of breath) | |

Gastrointestinal: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice | <input type="checkbox"/> abnormal stool color | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn | <input type="checkbox"/> nausea | <input type="checkbox"/> abnormal stool consistency | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | |

Female: I DENY having any of the symptoms/problems and/or using any of the items listed below.

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> hormone therapy | <input type="checkbox"/> vaginal bleeding | <input type="checkbox"/> burning urination | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> vaginal discharge | <input type="checkbox"/> urine retention | # of pregnancies: _____ |
| <input type="checkbox"/> discharge from nipple | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> frequent urination | # of living children: _____ |
| <input type="checkbox"/> cramps | <input type="checkbox"/> Abnormal Pap test | <input type="checkbox"/> birth control | Age of onset of Period: _____ |
| | Last Pap date: _____ | method: _____ | Cycle; _____ days (start to start) |

Male: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> burning urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> prostate problems | <input type="checkbox"/> discharge from penis |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/dribbling | <input type="checkbox"/> urine retention | <input type="checkbox"/> lump in testicles |

Endocrine: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> cold intolerance | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> goiter | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> hair loss | <input type="checkbox"/> voice changes |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> abnormal frequency of urination | <input type="checkbox"/> heat intolerance | |

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Urinary: I DENY having any of the symptoms or problems listed below.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> kidney stones | <input type="checkbox"/> burning with urination | <input type="checkbox"/> blood in urine | <input type="checkbox"/> sexual problems |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> slow urine flow | <input type="checkbox"/> venereal disease | |
| <input type="checkbox"/> bladder or kidney infection | <input type="checkbox"/> difficulty starting or controlling urination | | |

Skin: I DENY having any of the symptoms or problems listed below.

- | | | | |
|--|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss | <input type="checkbox"/> itching | <input type="checkbox"/> skin lesions / ulcers |
| <input type="checkbox"/> changes in skin color | <input type="checkbox"/> hives | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities |
| <input type="checkbox"/> history of skin disorders | <input type="checkbox"/> hair growth | <input type="checkbox"/> rash | |

Bones/Joints/Muscles: I DENY having any of the symptoms or problems listed below.

- painful or swollen joints persistent back or neck pain muscle cramps osteoporosis

Nervous System: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> loss of memory | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremors |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> facial numbness | <input type="checkbox"/> seizures/epilepsy | <input type="checkbox"/> stress | <input type="checkbox"/> unsteadiness of gait/
loss of balance |
| <input type="checkbox"/> limb weakness | <input type="checkbox"/> limb numbness | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes | |
| <input type="checkbox"/> headache | | | | |

Psychologic: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|--|--------------------------------------|--|
| <input type="checkbox"/> crying spells | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> memory problems | <input type="checkbox"/> bi-polar disorder | <input type="checkbox"/> depression | <input type="checkbox"/> mood change |
| <input type="checkbox"/> loss or change in appetite | <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> insomnia | <input type="checkbox"/> job or family
difficulty |
| <input type="checkbox"/> loss of interest in previously
enjoyable things | <input type="checkbox"/> suicide attempts | <input type="checkbox"/> confusion | |

Allergy: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> anaphalaxis | <input type="checkbox"/> itching | <input type="checkbox"/> chronic nasal congestion | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> acute nasal congestion | <input type="checkbox"/> rash | |

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? Yes No. Why? _____

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other _____

For how long? _____ Were they prescribed by a doctor? Yes or No.

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Name: _____

Date: _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage / Times Daily	For What Condition?	How long have you been taking this?

Medication Allergies: List ANY/ALL medications you are allergic to and the type of reaction. Be Specific.

Medications	Reaction

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you been taking this?

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental sugery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsilectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | _____ |

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> chicken pox | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> atopic dermatitis (eczema) | <input type="checkbox"/> Crohn's/colitis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> allergies/hayfever | <input type="checkbox"/> depression | <input type="checkbox"/> HIV | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> measles | <input type="checkbox"/> spina bifida |
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear infections | <input type="checkbox"/> mumps | <input type="checkbox"/> other: |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> fetal drug exposure | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> food allergies (list below) | <input type="checkbox"/> rash | |

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Name: _____

Date: _____

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

Adult Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> alzheimers | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoid) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> Crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | _____ |

Females ONLY: Ob/Gyn Mark all that apply below.

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 C-sections	_____ Number of vaginal deliveries
_____ Number of miscarriages	_____ Number of terminated pregnancies
I... <input type="checkbox"/> am currently pregnant	<input type="checkbox"/> am NOT currently pregnant

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> other: _____ |

Immunizations: Please list the date(s) next to the immunization, if known.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> adenovirus | <input type="checkbox"/> hepatitis C | <input type="checkbox"/> pertussis | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> anthrax | <input type="checkbox"/> influenza | <input type="checkbox"/> pneumococcal | <input type="checkbox"/> tularemia |
| <input type="checkbox"/> botulism | <input type="checkbox"/> IPV (polio) | <input type="checkbox"/> pneumovax | <input type="checkbox"/> typhoid |
| <input type="checkbox"/> flu | <input type="checkbox"/> Japanese encephalitis | <input type="checkbox"/> PPD (mantoux test- TB) | <input type="checkbox"/> varivax (chicken pox) |
| <input type="checkbox"/> haemophilus B | <input type="checkbox"/> lyme disease | <input type="checkbox"/> rabies | <input type="checkbox"/> whooping cough (pertussis) |
| <input type="checkbox"/> hepatitis A | <input type="checkbox"/> measles | <input type="checkbox"/> rotavirus | <input type="checkbox"/> yellow fever |
| <input type="checkbox"/> hepatitis B | <input type="checkbox"/> meningococcal | <input type="checkbox"/> rubella | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> diphtheria | <input type="checkbox"/> MMR | <input type="checkbox"/> smallpox | _____ |
| <input type="checkbox"/> DTaP (diphtheria, tetanus, pertussis) | <input type="checkbox"/> mumps | <input type="checkbox"/> tetanus | _____ |

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Non-Drug Allergies: Mark all that apply below.

- | | | | |
|--|--|------------------------------------|------------------------------------|
| <input type="checkbox"/> adhesive tape | <input type="checkbox"/> eggs | <input type="checkbox"/> newsprint | <input type="checkbox"/> shellfish |
| <input type="checkbox"/> animals | <input type="checkbox"/> feathers | <input type="checkbox"/> nuts | <input type="checkbox"/> smoke |
| <input type="checkbox"/> bee sting | <input type="checkbox"/> food coloring | <input type="checkbox"/> peanuts | <input type="checkbox"/> soap |
| <input type="checkbox"/> chocolate | <input type="checkbox"/> latex | <input type="checkbox"/> perfumes | <input type="checkbox"/> soy |
| <input type="checkbox"/> dairy | <input type="checkbox"/> mold | <input type="checkbox"/> pollen | <input type="checkbox"/> wheat |
| <input type="checkbox"/> other: _____ | | | |

Social History: Mark all that apply below.

Tobacco:	<input type="checkbox"/> None	<input type="checkbox"/> Pipe/Cigar	<input type="checkbox"/> Chew	Cigarettes: Amt/day _____	
				How long? _____	<input type="checkbox"/> Quit?
Alcohol:	<input type="checkbox"/> 1/wk-2/day	<input type="checkbox"/> Weekends	<input type="checkbox"/> None	<input type="checkbox"/> Over 2 daily	<input type="checkbox"/> Quit?
Coffee:	<input type="checkbox"/> 0-4 cups daily	<input type="checkbox"/> More: _____		Last Tetanus shot date: _____	
Meals?	<input type="checkbox"/> Reg low-fat	<input type="checkbox"/> Regular	<input type="checkbox"/> Often Skip	<input type="checkbox"/> Fast food	
Exercise:	<input type="checkbox"/> Regular	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Rarely	<input type="checkbox"/> No	
Use of Seat Belts	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No		
Use of Street Drugs	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details: _____		
Treatment of					
Alcohol abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details: _____		
Treatment of					
Drug abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details: _____		

Family History: Mark all that apply below.

Family History	Age	Deceased	Alcoholism	Arthritis	Bleeds easily	Cancer	Diabetes	Epilepsy	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Mental Illness	Migraine	Stroke	TB	Thyroid Disease	Other
Father																		
Mother																		
Bro/Sis																		
Bro/Sis																		
Spouse																		
child																		
child																		

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QUADRUPLE VISUAL ANALOGUE SCALE
(QUAD-VAS)

Patient Name: _____

Date: _____

Please read carefully:

Instructions: Please circle the number and list the area of your complaint that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

No pain _____ *Headache* _____ *Neck* _____ *Low Back* _____ worst possible pain
pain 0 1 2 3 4 5 6 7 8 9 10

1 – What is your pain RIGHT NOW?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

Examiner

Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.