

# Life Essentials Health Center – NEW PATIENT APPLICATION

Whom may we thank for referring you to our office? \_\_\_\_\_ Today's Date: \_\_\_\_\_

HR#: \_\_\_\_\_

## PATIENT DEMOGRAPHICS:

Name: \_\_\_\_\_ Birth Date: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  M  F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_ Mobile#: \_\_\_\_\_  
 Home#: \_\_\_\_\_ Work#: \_\_\_\_\_  
 Work#: \_\_\_\_\_ Fax#-Home or Work: \_\_\_\_\_  
 Driver's License#: \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Name of Spouse: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_  
 Names & Ages of Children: \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Number \_\_\_\_\_

## HISTORY OF COMPLAINT:

- Please identify the condition(s) that brought you to our office: Primary: \_\_\_\_\_  
 Secondary: \_\_\_\_\_ 3rd: \_\_\_\_\_ 4th: \_\_\_\_\_
- On a scale of 0-10 (10=worst pain and 0=no pain), rate your above complaints, by circling the number **IF APPLICABLE**:  
 Primary Complaint: 0 1 2 3 4 5 6 7 8 9 10      Secondary Complaint: 0 1 2 3 4 5 6 7 8 9 10  
 3rd Complaint: 0 1 2 3 4 5 6 7 8 9 10      4th Complaint: 0 1 2 3 4 5 6 7 8 9 10
- When did the complaint(s) begin? \_\_\_\_\_ When is the complaint(s) the worst?  AM  Mid-Day  PM
- How did the "injury" (complaint) happen? \_\_\_\_\_
- How long does it last?  It is constant  I experience it on and off during the day  It comes and goes throughout the week
- What relieves your symptoms? \_\_\_\_\_ What makes it feel worse? \_\_\_\_\_
- Condition(s) treated in the past?  No  Yes – If yes, when? \_\_\_\_\_ By whom? \_\_\_\_\_
- How long were you under care? \_\_\_\_\_ What were the results? \_\_\_\_\_
- Name of Previous Chiropractor: \_\_\_\_\_ Location: \_\_\_\_\_
- What is your motivation for wanting to become healthy? \_\_\_\_\_

### LIST RESTRICTED ACTIVITY:

### CURRENT ACTIVITY LEVEL:

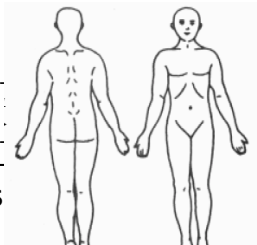
### USUAL ACTIVITY LEVEL:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is your problem/complaint the result of ANY type of accident?  No  Yes  
 Identify any other injury(s) minor or major, that the Doctor should know about?: \_\_\_\_\_



## DESCRIBE YOUR SYMPTOMS: PLEASE MARK the areas on the diagram with the following LETTERS

R = Radiating    B = Burning    D = Dull    A = Aching    N = Numbness    S = Sharp/Stabbing    T = Tingling

**PAST HISTORY:**

1. Have you suffered with any of this or a similar problem in the past?  No  Yes – If yes, How many times? \_\_\_\_\_  
When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_
2. Other forms of treatment tried?  No  Yes – If yes, please state what type of treatment: \_\_\_\_\_,  
and who provided it: \_\_\_\_\_ How long ago? \_\_\_\_\_  
What were the results?  Favorable  Unfavorable – Please explain: \_\_\_\_\_
3. Please identify any and all types of jobs you have had that have imposed any physical stress on you or your body:  
\_\_\_\_\_
4. If you have ever been diagnosed with any of the following conditions, please indicate with a **P** (past), **C** (current) or **N** (never):  
 Broken Bone     Dislocations     Tumor     Rheumatoid Arthritis     Fracture     Disability  
 Cancer     Heart Attack     Osteo Arthritis     Cerebral Vascular     Other serious conditions
5. Please, identify ALL PAST and CURRENT conditions you feel may be contributing to your present complain:  

HOW LONG AGO?	TYPE OF CARE RECEIVED?	BY WHOM?
INJURIES >> _____	>> _____	>> _____
SURGERIES >> _____	>> _____	>> _____
CHILD DISEASES >> _____	>> _____	>> _____
ADULT DISEASES >> _____	>> _____	>> _____

**SOCIAL HISTORY:**

1. Smoking:  Cigars  Pipe  Cigarettes >> How often:  Daily  Weekends  Occasionally  Never
2. Alcoholic Beverages (Consumption): >> How often:  Daily  Weekends  Occasionally  Never
3. Recreational Drug Use: >> How often:  Daily  Weekends  Occasionally  Never
4. How does your present complaint affect your recreational activities/exercise regime/hobbies? \_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY:**


1. Does anyone in your family suffer with the same complaint(s)?  No  Yes  
If Yes, whom?  Grandmother  Grandfather  Mother  Father  Sister  Brother  Son  Daughter
2. Have they ever been treated for their condition(s)?  No  Yes  I don't know
3. Any other hereditary conditions the Doctor should be aware of?  No  Yes: \_\_\_\_\_

**FEMALES ONLY** → please read carefully, and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

- The first day of my last menstrual cycle was on: \_\_\_\_\_ (Date)
- I have been provided a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant.

**REGARDING: X-rays/Imaging Studies**

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination if the doctor has deemed necessary in my case.

\_\_\_\_\_  Witness Initials

Patient or Authorized Person's Signature Date

# ACTIVITIES OF DAILY LIVING (SYMPTOMS/MEDICATIONS)

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Daily Activities: Effects of current conditions on performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

Please mark **P** for in the Past, **C** for Currently have, and **N** for Never:

- \_\_\_ Headache
- \_\_\_ Neck Pain
- \_\_\_ Jaw Pain, TMJ
- \_\_\_ Shoulder Pain
- \_\_\_ Upper Back Pain
- \_\_\_ Mid Back Pain
- \_\_\_ Low Back Pain
- \_\_\_ Hip Pain
- \_\_\_ Pregnant (now)
- \_\_\_ Dizziness
- \_\_\_ Prostate Problems
- \_\_\_ Ulcers
- \_\_\_ Frequent Colds/Flu
- \_\_\_ Loss of Balance
- \_\_\_ Impotence/Sexual Dysfun.
- \_\_\_ Heartburn
- \_\_\_ Convulsions/Epilepsy
- \_\_\_ Fainting
- \_\_\_ Digestive Problems
- \_\_\_ Heart Problem
- \_\_\_ Shoulder Pain
- \_\_\_ Tremors
- \_\_\_ Double Vision
- \_\_\_ Colon Trouble
- \_\_\_ High Blood Pressure
- \_\_\_ Chest Pain
- \_\_\_ Blurred Vision

- \_\_\_ Diarrhea/Constipation
- \_\_\_ Low Blood Pressure
- \_\_\_ Pain w/Cough/Sneeze
- \_\_\_ Ringing in Ears
- \_\_\_ Menopausal Problems
- \_\_\_ Asthma
- \_\_\_ Foot or Knee Problems
- \_\_\_ Hearing Loss
- \_\_\_ Menstrual Problem
- \_\_\_ Difficulty Breathing
- \_\_\_ Sinus/Drainage Problem
- \_\_\_ Depression
- \_\_\_ PMS
- \_\_\_ Lung Problems
- \_\_\_ Back Curvature
- \_\_\_ Swollen/Painful Joints
- \_\_\_ Irritable
- \_\_\_ Bed Wetting
- \_\_\_ Kidney Trouble
- \_\_\_ Scoliosis
- \_\_\_ Skin Problems
- \_\_\_ Mood Changes
- \_\_\_ Learning Disability
- \_\_\_ Gall Bladder Trouble
- \_\_\_ Numb/Tingling arms, hands, fingers
- \_\_\_ ADD/ADHD
- \_\_\_ Eating Disorder

- \_\_\_ Liver Trouble
- \_\_\_ Numb/Tingling legs, feet, toes
- \_\_\_ Allergies
- \_\_\_ Trouble Sleeping
- \_\_\_ Hepatitis (A,B,C)

**List Prescription & Non-Prescription medications you take:**

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# INITIAL HEALTH PROFILE

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## INITIAL NERVE SYSTEM PROFILE:

1. What was your most recent auto accident? \_\_\_\_\_
  - a. What speed was the collision? \_\_\_\_\_
  - b. Type of impact:  Front Impact  Side Impact  Rear Impact
  - c. Was treatment received?  No  Yes – If yes, please describe: \_\_\_\_\_
2. When was your most recent strain/stress at work? \_\_\_\_\_
  - a. Please describe the manner of the injury: \_\_\_\_\_
  - b. Was treatment received?  No  Yes – If yes, please describe: \_\_\_\_\_
  - c. Does your job require you to remain in long-term stressful postures?  No  Yes  
(i.e. all day seating, repeated lifting, long-term computer use)
3. Any spinal traumas in the past?  No  Yes – If yes, please describe: \_\_\_\_\_
  - a. Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field \_\_\_\_\_
  - b. Trauma as a child: (fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident) \_\_\_\_\_
  - c. Work around the house: (lifting, bending, woke up with stiff neck, "back went out") \_\_\_\_\_  
\_\_\_\_\_

## INITIAL NUTRITIONAL PROFILE:

1. Have you tested with high triglycerides or high cholesterol?  No  Yes – If Yes, Values: \_\_\_\_\_
2. Have you tested with high blood pressure?  No  Yes
3. Are you diabetic?  No  Yes
4. Have you been diagnose as pre-diabetic or with metabolic syndrome?  No  Yes
5. Do you eat breakfast daily from Monday to Friday?  No  Yes
6. How many days per week do you skip one meal?  0  1  2  3  4+
7. How many fast food, refined foods, or pre-pared meals do you eat per week?  0  1-3  4-6  7+
8. How many servings of fruit do you have on a given day?  0-1  2-3  4+
9. How many servings of vegetables do you have on a given day?  0-1  2-3  4-5
10. Do you regularly drink (1 or more per day) any of the following? (circle all that apply)  
 Diet Soda/Pop  Coffee  Juice  Milk  Soda  Alcohol
11. Please list any supplements you take regularly: \_\_\_\_\_

**INITIAL FITNESS PROFILE:**

1. How many times per week do you exercise? \_\_\_\_\_
2. Cardiovascular: \_\_\_\_\_ Hours \_\_\_\_\_ Days per Week
3. Weight Training: \_\_\_\_\_ Hours \_\_\_\_\_ Days per Week
4. Low Impact (yoga, etc.): \_\_\_\_\_ Hours \_\_\_\_\_ Days per Week
5. What is your target weight? \_\_\_\_\_
6. What is your current weight? \_\_\_\_\_
7. How willing are you to change any of these things to reach your health goals? (Scale of 1-10) \_\_\_\_\_

**INITIAL TOXICITY PROFILE:**

1. Are you regularly exposed to cleaning products or industrial chemicals?  No  Yes
2. Have you ever noticed mold growing in your home or your place of work?  No  Yes
3. Does your home, work, school, or car have damp or mildew smell?  No  Yes
4. Have you received a full standard profile of vaccinations?  No  Yes
5. Do you receive yearly flu shots?  No  Yes – If Yes, How many have you received? \_\_\_\_\_ (estimate)
6. Have any members of your family been diagnosed with fibromyalgia, chronic fatigue, or multiple chemical sensitivities?  No  Yes
7. Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)?  No  Yes

**INITIAL STRESS PROFILE:**

1. Do you get an average of 8 hours of sleep per night?  No  Yes
2. Do you average less than 7 hours of sleep per night?  No  Yes
3. Do you ever take pills to go to sleep or relax?  No  Yes
4. Do you often feel short on time and procrastinate on projects?  No  Yes
5. Do you experience feelings of anxiety about completing tasks?  No  Yes
6. Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby?  No  Yes
7. Do you rely more on your memory than a planner and action list to get things done?  No  Yes
8. Do you take time to pray, meditate, or visualize on a regular basis?  No  Yes

Doctor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# INFORMED CONSENT

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## **REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:**

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Life Essentials will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Dr Brian Class will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment.

Treatment Objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Life Essentials Health Center have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_\_  
Date



*Witness Initials*

# Notice of Privacy Practice

I have read the office Patient Privacy Notice, which was handed to me and is also located in the notebook in the waiting room. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the front desk. At this time, I do not have any questions regarding my rights or any of the information I have received.

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
HR#:

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness's Signature

\_\_\_\_\_  
Date