LifeWorks

Shawnee: 22742 Midland Drive, Shawnee, KS 66226 PH 913.441.2293

Comprehensive Health History Forms

Patient Information

Legal Name: _____ DOB: _____ Age: _____ Sex: M or F
(last) (first) (middle initial)

St Address: _____ City: _____ State _____ Zip _____

Home Ph: (_____) _____ Cell Ph: (_____) _____ **Best to Reach:** Phone Text Email

Email: _____ SS# *(need for Ins Verification)*:_____

Can we voice record your appointment for training purposes only? Yes or No

Race: □ American Indian/Alaska Native □ Asian □ Black or African American □ White (Caucasian)
□ Native Hawaiian or Pacific Islander □ Other □ I Decline to Answer

Ethnicity: □ Hispanic □ Non Hispanic □ I Decline to Answer

Status: □ Single □ Married □ Widowed □ Divorced □ Separated □ Minor

If Patient is a Minor: Parent/Guardian Name: _____ Ph: (_____) _____

Occupation: _____ Employer: _____ Work Ph: (_____) _____

In Case of Emergency: Name: _____ Relationship _____ Ph: (_____) _____

How Did You Hear About Us? □ Dr Referral _____ □ Patient Referral _____

□ Facebook □ Google □ Walk-In □ Health Talk/Event □ Other: _____

Medical Information

Primary Care Physician's Name _____ Phone: (_____) _____

Clinic Name _____ Fax: (_____) _____

I allow my health progression to be shared with my primary care physician: □ *Yes* □ *No*

History of Present Illness

What brings you in to the office today (major complaint)? _____

Have you seen a MD/PT or DC for this problem? □ Yes □ No

Previous Treatment for this condition: _____

Did it resolve the condition: □ Yes □ No Explain: _____

How many years have you had the pain (complaint)? _____

How does this problem interfere with your daily life? _____

Have you considered surgery? □ *Yes* □ *No* Have you had any Nerve Testing/EMG? □ *Yes, when* _____ □ *No*

What is your main concern about your complaint(s)? _____

On a Scale from 1 to 10 (10 high), what is your interest in getting help for your (complaint)?1 2 3 4 5 6 7 8 9 10

List all recent X-ray's, CT Scans and MRI, when and state Results: _____

_____

List other current or ongoing health problems in order of priority and your treatments:

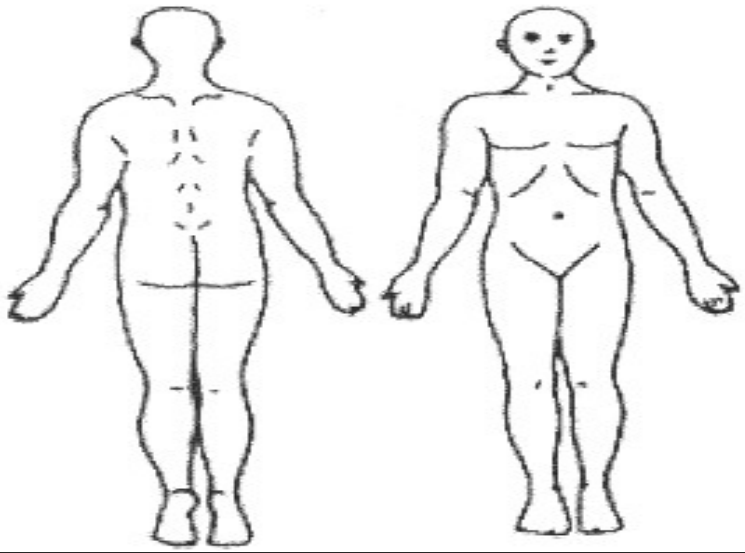
1. _____
2. _____
3. _____

 By *initialing I am agreeing that I have completed this page to the best of my knowledge.* Pt Initials _____Date_____

Current Condition

Label on the Diagram the CURRENT Areas of Discomfort:

A=Aching	B=Burning
C=Cold	CR=Cramps
D=Dull	H=Hot
HY=Hypersensitive	N=Numbness
P=Pins&Needles	S=Stabbing
SH=Sharp	SP=Spasms
ST=Stiffness	SW=Swelling
T=Throbbing	TI=Tingling
W=Weakness	



Review of Systems Check appropriate box and provide date of onset and circle if options

○= past □= ongoing ◇= never

○ □ ◇ Anesthesia Problems
○ □ ◇ Aneurysm _____
○ □ ◇ Blood Clots
Legs / Lungs
○ □ ◇ Blood Thinners
○ □ ◇ Chest Pain
○ □ ◇ Chemical Exposure
Pesticides / Agent Orange
○ □ ◇ Constipation / Diarrhea
○ □ ◇ COPD
○ □ ◇ Cough
Recurrent / Chronic
○ □ ◇ Diabetes Type 1 / Type II
○ □ ◇ Dizziness
○ □ ◇ Emphysema
○ □ ◇ Epilepsy
○ □ ◇ Fibromyalgia
○ □ ◇ GERD
○ □ ◇ Gout
○ □ ◇ Headaches / Migraines
○ □ ◇ Heart Disease / Palpitations
○ □ ◇ Hepatitis
○ □ ◇ Hernia
○ □ ◇ Blood Pressure: High / Low
○ □ ◇ High Cholesterol
○ □ ◇ HIV
○ □ ◇ Kidney Disease
○ □ ◇ Lung Disease
○ □ ◇ Lupus
○ □ ◇ MRSA
○ □ ◇ Neuropathy
○ □ ◇ **Pacemaker/Defibrillator**
○ □ ◇ Paralysis
○ □ ◇ Plantar Fasciitis
○ □ ◇ Polio
○ □ ◇ Shingles
○ □ ◇ Skin Pigment Changes
○ □ ◇ Sleep Apnea
○ □ ◇ Spider Veins
○ □ ◇ Stroke / TIA
○ □ ◇ Swelling Feet/Ankles
○ □ ◇ Tuberculosis
○ □ ◇ Ulcers / Amputations
○ □ ◇ Vascular Disease
○ □ ◇ Varicose Veins
○ □ ◇ Vitamin Deficiency
B12 or D3

Musculoskeletal

○ □ ◇ Arthritis
○ □ ◇ Degenerative Disc
○ □ ◇ Disc Bulge
○ □ ◇ Disc Herniation
○ □ ◇ Fusion: _____
○ □ ◇ Hernia
○ □ ◇ Joint Replacement
○ □ ◇ Knee Pain
○ □ ◇ Lower Back Pain
○ □ ◇ Neck Pain
○ □ ◇ Sciatica: R L or Both
○ □ ◇ Spinal Fractures
○ □ ◇ Spinal Stenosis
○ □ ◇ Spinal Arthritis
○ □ ◇ Upper Back Pain
○ □ ◇ Other
_____
○ □ ◇ Other
_____
○ □ ◇ Other
_____
○ □ ◇ Other
_____

○ □ ◇ Cancer: Location _____ Year _____

Did you have Radiation? □ *Yes* □ *No* Chemotherapy? □ *Yes* □ *No* Medication? □ *Yes, Type* _____ □ *No*

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Family History

Biological Mother □ Living □ Deceased: Cause of Death: _____

Relevant Health History: _____

Biological Father □ Living □ Deceased: Cause of Death: _____

Relevant Health History: _____

Medical History

Injuries / Accidents

○ None

Date	Reason

Surgeries

○ None

Date	Reason

Hospitalizations

○ None

Date	Reason

Lifestyle History

Check Your Exercise Levels:

□ Inactive □ Light Activity □ Moderate Activity □ Heavy Activity □ Vigorous Activity

Please check all that apply:

Current Tobacco User □ No □ Yes, Type _____ Amt/Day: _____

Previous Tobacco User □ No □ Yes, Type _____ Amt/Day: _____

Are you exposed to 2nd hand smoke regularly? □ Yes □ No

Current Alcohol Drinker □ No □ Yes, How many drinks per week? □ 1-3 □ 4-6 □ 7-10 □ >10

Previous Alcohol Drinker □ No □ Yes, How many drinks per week? □ 1-3 □ 4-6 □ 7-10 □ >10

Do you currently or have previously used recreational drugs? □ No □ Yes, what types and method (IV, inhaled, smoked, etc.) _____

Work Activity Level:

□ Full-Time □ Part-Time □ Homemaker □ Student □ Unemployed

How many hours per day do you work? □ <5 □ 6-8 □9-10 □ >10

Are You Mostly? □ Sitting □ Walking □ Standing

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Medication Information

Current Medication (Rx)	Dose / Frequency	Start Date / Reason for Use

Nutritional Supplements (non Rx)	Dose / Frequency	Start Date / Reason for Use

For any additional medications and supplements, please list on additional paper

Have your medications or supplements ever caused unusual side effects or problems? □ No □ Yes, Describe: _____

Do you have any surgical devices or pins/screws in your body? □ No □ Yes, Where?

_____

List all allergies, intolerances or sensitivities:

Drugs / Medication: □ None □ Yes, List: _____

Food: □ None □ Yes, List: _____

Environmental/Chemical: □ None □ Yes, List: _____

Daily Activities *Effects of Current Condition on Daily Performance*

Please mark for each CURRENT Condition: 1=No Effect 2=Slightly Limited 3=Limited 4=Mostly Limited 5=Unable to Perform

Bending	1 2 3 4 5	Cleaning	1 2 3 4 5	Climbing	1 2 3 4 5
Computer Work	1 2 3 4 5	Concentrating	1 2 3 4 5	Cooking	1 2 3 4 5
Dancing	1 2 3 4 5	Dressing	1 2 3 4 5	Driving	1 2 3 4 5
Jumping	1 2 3 4 5	Lifting	1 2 3 4 5	Playing Sports	1 2 3 4 5
Pushing	1 2 3 4 5	Running	1 2 3 4 5	Sexual Activity	1 2 3 4 5
Sitting	1 2 3 4 5	Sit to Stand	1 2 3 4 5	Sleeping	1 2 3 4 5
Stairs	1 2 3 4 5	Standing	1 2 3 4 5	Walking	1 2 3 4 5
Working	1 2 3 4 5	Vacuuming	1 2 3 4 5	Yardwork	1 2 3 4 5

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Accident Information

Is your condition due to an accident? □ No □ Yes, Date _____

Type of Accident: □ Auto □ Work □ Home □ Other _____

To whom have you made a report of your accident? □ Auto Insurance □ Employer □ Work Comp □ Other_____

Attorney Name: (*if applicable)* _____ Ph: (_____) _____

Insurance Information

Who is responsible for this account? □ Self □ Other_____

Name on Account and Relationship _____

Insurance Company: _____Policy #:_____ Group #:_____

Is the patient covered by a Supplement/Secondary Insurance? □ Yes □ No

Name on Account and Relationship _____

Insurance Company: _____Policy #:_____ Group #:_____

Assignment and Release I understand and agree that (regardless of whatever health or medical benefits I have), I am ultimately responsible to pay LIFEWORKS INTEGRATIVE HEALTH/INTEGRATIVE HEALTH PARTNERS, LLC, the balance due on my account for any professional services rendered and for any supplies, tests or medications provided.
I hereby authorize payment of any health insurance or medical plan benefits directly to LIFEWORKS INTEGRATIVE HEALTH/INTEGRATIVE HEALTH PARTNERS, LLC, for medical services rendered and for any supplies, tests or medications provided. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. Patient irrevocably assigns all of his/her rights and benefits and right to pursue enforcement of such benefits, under any policy of insurance, indemnity, health plan (including self-funded), or any collateral source to LIFEWORKS INTEGRATIVE HEALTH/INTEGRATIVE HEALTH PARTNERS, LLC, including the right to submit claims for reimbursement and payment for services rendered, and authorizes direct payment to the provider of any benefits otherwise payable to or on behalf of the Patient. Patient assigns to Provider his/her right to pursue payment, appeals, claims, causes of action, penalties, administrative, and/or legal remedies including the right to bring claims under enforcement provisions of ERISA, against any responsible source of payment including but not limited to any insurer, health plan (including self-funded), health carrier, hospital or medical service corporation, ERISA plan or administrator, for any and all benefits due me under my benefit plan. Provider is expressly authorized to bring any and all claims to enforce my rights under ERISA, including right to payment, breach of fiduciary duty, breach of contract, civil penalties, or any other claim or remedy. Provider is authorized to make such claims, institute legal or alternative dispute resolution proceedings, enter into settlements or compromises and any other acts necessary to pursue my rights and benefits. This assignment extends to any affiliates, agents, and/or assignees of Provider. Patient hereby appoints Provider as his/her authorized representative and attorney-in-fact for such activities, and authorizes Provider to take such actions in the name of Provider and/or the Patient. If I receive payment directly from any source for the services I receive from Provider, I agree it is my duty and responsibility to immediately pay any such amounts to Provider.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative | Print Name of Patient, Parent, Guardian or Personal Representative

_____ _____
Relationship to Patient | Date

We ask that you realize that we do NOT work for an insurance company. Rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However; the treatment we recommend and the fees we charge **WILL ALWAYS BE BASED ON YOUR INDIVIDUAL NEEDS, NOT YOUR INSURANCE COVERAGE.**

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