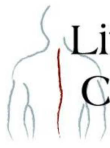

LifeWorks Chiropractic Clinic
DR. JUSTIN THOLE, D.C.

2032 Lowe St. #102 • Fort Collins, CO 80525 • www.lifeworks-chiropractic.com
Tel: (970)377-1810 • Fax: (970)377-1815

New Patient Registration

PLEASE NOTE: You MUST save this file to your desktop before and after completing!

PATIENT INFORMATION

Date ________________ First Name ____________________ Middle Name ____________ Last Name ____________________

SSN _____________________ Sex _____________ Birth Date ________________ Height _____ Weight _______________

__ Married Widowed Single Minor Separated Divorced Partnered for ____ years

Spouse Name ______________________ Number of Children _______

Address ____ City __________________ State ________ Zip _________

Cell Phone ________________________ Work Phone ________________________ Home Phone ________________________

Cell Phone Carrier __________________________________ Email ____

Emergency Contact ___________________________ Relation _____________________ Phone ______________________________

REFERRAL INFORMATION

How did you hear about the clinic?

Another Provider______________________ Event_________________________ Family/Friend_________________

Insurance___________________ Google Social Media___________________ Website ZocDoc

Live/Work Nearby VA Referral Other_______________________________________

EMPLOYER INFORMATION

Employed Full-time Student Part-time Student Homemaker Retired Unemployed

Employer/School Name___________________________________ Occupation____

Employer/School Address ____

REASON FOR VISIT

Describe in your own words why you need to come in for an appointment: (i.e. pain relief, correction care, overall wellness, etc)

What are some goals that coincide with care? (i.e. start working out again, pick up grandchildren, etc)

Injuries

Type of Injury____ Injury Date___________

How did it occur? Work Automobile Fall Other____

Received other care for this? Yes No If yes, where and by whom? ____

PERSONAL HEALTH INFORMATION

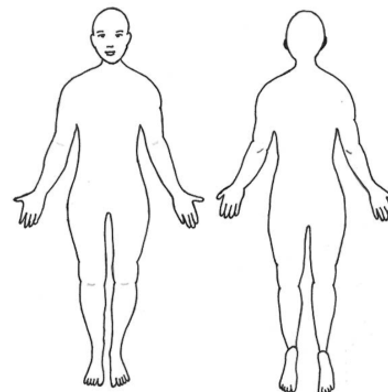
Complaints/Concerns

Please list your chief symptoms in order of decreasing severity, starting with the worst one.

Problem	Onset	Frequency	Severity
E.g. Headaches	*June 2007*	*4 times per week*	*Mild / Moderate / Severe*
1.			
2			
3.			
4			

Symptoms and Pain

Pain level on a scale of 1 - 10 (10 is excruciating pain) At its best?_________ At its worst?_________ Now?_________



Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? Constant Frequent Occasional Intermittent

Does it interfere with your: Work Sleep Daily Routine Recreation Other

Since your problem began, is your pain: Increasing Decreasing No Change

What activities make pain BETTER? Sitting Standing Movement/Exercise
Lying Down Sleep/Rest Other____________________________________

What activities make pain WORSE? Sitting Standing Movement/Exercise
Coughing/Sneezing Sleep/Rest Other______________________________

Have you tried anything for the pain? No Yes,______________________________

Please mark in each column which best describes your activity:

Exercise	**Work Activity**	**Habits**	
None	Sitting	Smoking	Packs/Day_____Years_____
Moderate	Standing	Alcohol	Drinks/Week____________
Daily	Light Labor	Coffee/Caffeine	Cups/Day_______________
Heavy	Heavy Labor	High Stress Level	Reason_________________

Sleep

Average number of hours you sleep? ________ Do you have trouble falling asleep? Yes No

Do you feel rested upon awakening? Yes No Do you have problems with insomnia? Yes No

Do you snore? Yes No Do you use sleeping aids? Yes No Explain: __________________________

Allergies and Medication

List all allergies along with symptoms of reactions:

List all medications and supplements you are currently taking or have taken in the past month, including antibiotics, non-prescription and prescription drugs, vitamins, minerals and other nutritional supplements along with their doses:

Health Questionnaire

SKIN, HAIR, NAILS

- Eczema
- Itchy skin
- Dry scalp
- Oily scalp
- Rough, scaly skin
- Dry skin
- Oily skin
- Psoriasis
- Yellow skin
- Bruise easily
- Paper thin nails
- Pale skin
- Nail biting
- Baldness

EYES

- Blurring of vision
- Double vision
- Eyes fatigue easily
- Excessive tearing
- Lack of tearing
- Light bothers eyes
- Excessive itching
- Pain in eyeball

EARS

- Loss of hearing
- Pain in ears
- Discharge from ears
- Vertigo
- Ringing in ears

NOSE, SINUS

- Unusual nasal discharge
- Nose bleeds
- Pressure over eyes
- Pressure under eyes
- Obstruction of nose
- Frequent colds
- Sinusitis
- Nasal allergies
- Loss of sense of smell
- Any trauma to nose

MOUTH AND THROAT

- Pain in mouth
- Pain in throat
- Bleeding in gums
- Cavities
- Abscessed teeth
- Dentures
- Difficulty swallowing
- Changes in voice

RESPIRATORY

- Shortness of breath
- Can't breathe while lying down
- Can't sleep while lying down
- Dry cough
- Productive cough
- Coughing up blood
- Wheezing

GASTROINTESTINAL

- Poor appetite
- Constant nibbling
- Difficulty swallowing
- Indigestion
- Can't eat some foods
- Nausea & vomiting
- Jaundice
- Abdominal pain
- Change in bowel habits
- Diarrhea
- Constipation
- Hemorrhoids

GENITOURINARY

<u>Urination is</u>

- Frequent
- Normal
- Infrequent

<u>The amount is</u>

- High
- Normal
- Low
- Waking at night to urinate
- Abnormal intense desire to urinate
- Difficulty starting to urinate
- Decreased output
- Decreased output
- Pain on urination
- Dribbling
- Blood in urine
- Cloudy urine
- Lack of bladder control

VENEREAL DISEASE

- AIDS
- Syphilis
- Gonorrhea
- Other________________

SOCIAL HISTORY

- Smoking
- Other tobacco use
- Alcohol use
- Drink coffee or tea

<u>Diet is</u>

- Balanced
- Not balanced

<u>Rest is</u>

- Sufficient
- Not sufficient

<u>Recreation is</u>

- Sufficient
- Not sufficient

<u>My Family Stress is</u>

- Severe
- Moderate
- Minimal
- None

<u>How do you like your work?</u>

- I like it very much
- It's ok
- I hate it

<u>My job stress is</u>

- Severe
- Moderate
- Minimal
- None

- Nervousness
- Irritability
- Fatigue
- Depression
- Generally feel run-down
- Crave sweets
- Crave salts

WOMEN ONLY

Painful periods
Spotting
Vaginal discharge
Premenstrual symptoms
Irregular periods
Lumps in breast

#of Pregnancies______

#of Deliveries______

CARDIOVASCULAR

General swelling
Swelling in legs
Swelling in face
Swelling around eyes
Chest pain
Pounding heart beat
Heart "jumps"
Rapid heart beat
Blue or purple skin
Blue or purple nail beds
Fainting
Hypertension

VERTEBROBASILAR

Double vision
Loss of coordination
Irregular muscle movement
Ringing in ears
Heart attack
High blood pressure
Irregular heart beat
Hardening of the arteries
Areas of muscle weakness
Dizziness with nausea
Dizziness without nausea
Blurred vision
Fainting spells
Stroke
Diabetes
Pain over the heart
Cold hands and/or feet
Areas of numbness
Arthritis of the neck
Previous neck or head injury
Loss of memory
Inability to form words
Periods of blindness in one eye
Areas of abnormal sensations such as burning etc.
Blood vessel disease (phiebitis etc.)
Check if you smoke
Check if any of your family members have had a stroke
Check if you are taking birth control pills

MUSCULOSKELETAL SYSTEM

HEAD

Unusually frequent headaches
Unusually severe headaches
Head feels heavy
Vertigo
Light headedness
Loss of smell
Loss of taste
Loss of balance
Dizziness

NECK

Pain in neck
Neck pain with movement
Swelling in neck
Stiff neck
Pinched nerve in neck
Neck feels out of place
Muscle spasms in neck
Grinding sound in neck
Popping sound in neck
Limited neck movement

SHOULDERS

Pain in shoulders (L-R)
Pain across shoulders
Tension in shoulders
Muscle spasms in shoulders
Can't raise arm:
  Above shoulder level
  Over head

ARMS & HANDS

Pain in upper arm
Pain in forearm
Pain in hands
Pain in fingers
Sensation of pins & needles:
  In arms
  In fingers
Fingers go to sleep
Hands cold
Swollen joints in fingers
Loss of grip strength

MID BACK

Mid back pain
Pain between shoulder blades
Sharp stabbing pain
Dull ache
Pain front to back
Pain over kidney area
Muscle spasms in mid back

LOW BACK

Low back pain
Low back feels out of place
Muscles spasms in low back

HIPS, LEGS, & FEET

Pain in buttocks
Pain down leg
Knee pain
Leg cramps
Pins and needles in legs
Numbness in legs
Numbness in toes
Cold feet
Swollen ankles
Swollen feet

OFFICE POLICIES

(Updated as of 09.01.2020)

CHECKING IN:

- **Sign-In on the IPAD and update your symptoms** thoroughly at each and every appointment.
- Complete any paperwork when your appointment requires progress exams, insurance pre-authorization, release of medical records, progress evaluation, etc.

LATE ARRIVALS:

- **Front Desk will call after you are 10 minutes late to re-schedule.** We may still be able to see you for your appointment but make no guarantee of same day rescheduling or your ability to receive therapies in addition to your adjustment if time does not allow.

CHECKING OUT AT FRONT DESK:

- **Schedule or verify your next appointment** or preferably recurring group of appointments.
- **Make your payment each appointment** unless you have set-up a payment plan providing your debit/credit card to be ran monthly or have pre-paid your care plan in full.
- If you choose a "Pay As Go" plan, save your debit/credit card to your account preferably and your co-pay will be efficiently processed after each appointment. Multiple cards can be saved, revised or removed at any time.

SCHEDULING:

- **Doctors recommend and request that you always book a next appointment,** even if it's tentative. You can always re-schedule if necessary. This ensures that your care frequency is maintained and that your results will not be delayed or negatively impacted.
- Book out as far as your schedule will allow per phase of treatment. This will afford you to reserve time slots you want and ensure you stay on track with your prescribed care plan.
- If you are unable to keep an appointment - call, email or text right away to reschedule.
- Provide a reason if you have no other option but to cancel your appointment.
- **We reserve the right to charge for excessive missed appointments** and those cancelled without 24-hour notice. Front Desk will provide 3 warnings before a $25 charge is applied.

APPOINTMENT REMINDERS:

- **Opt into our appointment reminder system:** text or email reminders are sent 24 hrs ahead of time. Please don't rely solely on them as technology can occasionally glitch.
- You can reply to reminders if you are running late or need to reschedule an appointment.

***** Please cancel your appointment only for urgent or unexpected circumstances and emergencies. *****

INSURANCE:

- Until the Front Desk is able to verify your chiropractic benefits, you will be charged on a cash-basis. This is usually achievable on the 1st appointment but not always.
- **Make certain your insurance is applying your benefit** or paying their portion as contracted. If a claim is denied, we will attempt to re-bill. If denied a 2nd time, the patient is financially responsible and will need to contact their insurance directly to resolve any discrepancies.

COMMUNICATION:

- **Self-Advocate and track your care plan.** It is a team effort though, so ask the Front Desk about your care plan and/or payment plan status anytime upon checking in or out.
- Update Front Desk with any changes in your contact information, insurance, debit/credit card details, marital status, employment, medical issues, etc.

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I have both read and understood the Notice of Privacy Practices Act. No personal information will be given out unless I give permission to do so for medical purposes. I consent to the collection and use of the above information to **LifeWorks Chiropractic Clinic.** I authorize **LifeWorks Chiropractic Clinic** and its staff to examine and treat my condition as the practitioners see fit. I hereby authorize **LifeWorks Chiropractic Clinic** to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I, by clicking the submit button below, I agree to the financial policy described above and will adhere to all of its practices.

Please email this completed form to **frontdesk@lifeworks-chiropractic.com**.

By typing or signing your name below on the signature line, you are agreeing to all of the paragraph above.

____

Signature Date

Thank you!