



Welcome to Lifestyle Chiropractic & Wellness

Our mission at Lifestyle Chiropractic & Wellness is to help you achieve all of your health goals and needs. Whether your main reason for seeing us to get out of pain, increase your energy, lose weight or simply take your health to the next level, we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step in the process is to establish your current state of health and the overall function of your body. In order for us to assess this and understand the root cause of your symptoms, we will take you through a series of non-invasive examinations on your initial visit. This includes a full case history, nerve and muscle tests, postural analysis, functional movement assessment, bioimpedance analysis, spinal x-rays and blood pressure tests.

On the day of your visit, we ask that you wear comfortable clothing you can easily move in. We will take a postural photo of you, so please avoid multiple layers or bulky clothing. Full tights and pantyhose will need to be removed.

At your initial visit, please bring all completed paperwork (6 pages total).

Your initial assessment will take between 45-60 minutes. Please allow sufficient time for your appointment. If you have time constraints, contact our front desk prior to your visit.

PLEASE NOTE:

We have a 24-hour cancellation policy where the agreed upon initial exam fee will be charged if prior notice has not been given. If you are running late please contact the front desk at 920-499-3333. Late arrivals do run the risk of requiring a rescheduled appointment.



GENERAL INFORMATION

Please full out the forms *completely and accurately* to the best of your ability so we can quickly get you on the road to health.

Today's Date: _____ Social Security Number (SSN): _____ - _____ - _____

Name: _____
Last First Middle Initial

Street Address: _____ City: _____ State: _____ Zip Code: _____

Email (to enable the doctors to communicate with you): _____

Cell Phone Number: _____ Home Phone Number: _____

Gender: Male _____ Female _____ Age: _____ Birthdate: _____

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Partnered for ___ years Minor _____

Your Employer or School: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Occupation: _____

Spouse's Name: _____ Phone: _____

EMERGENCY CONTACT

Name of Emergency Contact: _____

Relationship: _____ Phone: _____

ACCIDENT INFORMATION

Is your condition due to an accident? Yes _____ No _____ Date of Accident: _____

Type of Accident: Auto _____ Work _____ Home _____ Other (please describe) _____

INSURANCE INFORMATION

Please complete this section regardless of your referral source. We are happy to verify your insurance coverage and provide your benefits information to you.

Who is responsible for this account? _____ Relationship to patient: _____

Name of Insurance Company: _____ ID#: _____

Subscriber Name: _____ Birthdate: _____

ASSIGNMENT AND RELEASE:

I certify that I, and / or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Chad Hoffman, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative Date

YOUR VISIT

We appreciate you choosing our office. Is there anyone we can thank for referring you? _____

Please indicate the main reason you are seeing us today: _____

MEDICAL HISTORY

Please list any significant conditions you've been diagnosed with or have been treated for over the course of your life: _____

Please list any surgeries you have had over the course of your life: _____

Are you allergic to any medications? Yes _____ No _____ If yes, please list: _____

MEDICATIONS YOU TAKE

CHOLESTEROL

BLOOD PRESSURE

STIMULANTS

BLOOD THINNERS

TRANQUILIZERS

PAIN KILLERS

ASPIRIN/ETC.

MUSCLE RELAXERS

INSULIN

THYROID

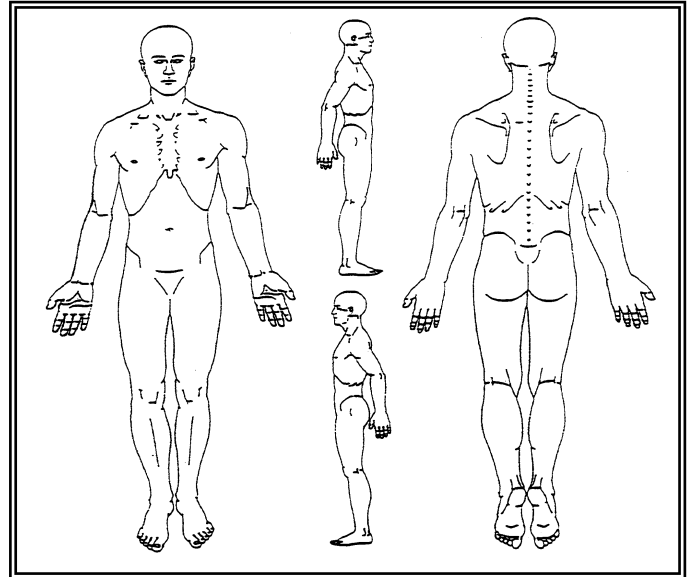
ANTI DEPRESSIONS

OTHER: _____

VITAMINS & SUPPLEMENTS: _____

If you are seeing us for a pain-related issue, **USE THE SYMBOLS** on the image to the right to show the type of pain you feel in each location:

- | | |
|-----------------|---------------------|
| X X X X X X X X | DULL / ACHY |
| / / / / / / / / | SHARP / STABBING |
| o o o o o o o o | NUMBNESS / TINGLING |
| s s s s s s s s | STIFF/TIGHT |
| - - - - - | BURNING |



- 0 = No Pain.** No Discomfort
- 1 = Minimal Discomfort.** Minor stiffness or tightness.
- 2 = Discomfort.** Stiff, tight, sore. Muscle fatigue.
- 3 = Minimal Pain.** More than just sore. Uncomfortable.
- 4 = Mild Pain.** Noticeable pain but tolerable.
- 5 = Moderate Pain.** Aggravating. Still allows movement.
- 6 = Strong Pain.** Quite aggravating. Movement slightly limited.
- 7 = Very Strong Pain.** Very aggravating. Movement definitely limited.
- 8 = Very, Very Strong Pain.** Extremely aggravating. Movement very limited.
- 9 = Severe Pain.** Brings tears. Almost impossible to move.
- 10 = Excruciating Pain.** Agony. Unbearable. Cannot move. ER.

Using the pain scale to the left, CIRCLE the pain level you experience when your problem is at its very worst.

Fill in the appropriate responses below:

Is there any radiating pain into the arms or legs? Yes _____ No _____ Is there any numbness or tingling? Yes _____ No _____

How often do you experience your problem? (Please indicate for each of the body locations, if applicable)

Constant (75-100% of the time): _____ Frequent (50-75% of the time): _____

Occasional (25-50% of the time): _____ Intermittent (0-25% of the time): _____

List any MDs or Chiropractors you've already seen for this problem: _____

What tests have you already had for this problem? X-rays _____ MRI _____ Myelogram _____ EMG / NCV _____ None _____

Other (please describe) _____

What makes your problem worse? Sitting _____ Standing _____ Changing Position _____ Walking _____ Bending _____

Lifting _____ Twisting _____ Reaching _____ Driving _____ Sleeping _____ Sneeze / Cough _____ Computer Work _____

Telephone _____ Going from Sit to Stand _____ Other (please describe) _____

FAMILY HISTORY

Mother: Living _____ Deceased _____ List any medical problems: _____
 Father: Living _____ Deceased _____ List any medical problems: _____
 List any problems common to your family: Cancer _____ Diabetes _____ Heart disease _____ High blood pressure _____ Stroke
 Arthritis Scoliosis Thyroid disease Osteoporosis Other (describe)

SOCIAL HISTORY

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Partnered for _____ years
 Do you have any children? Yes _____ No _____ If yes, how many? _____
 Are you currently employed? Yes _____ No _____
 Who is your current employer? _____ How long have you been at this job? _____
 What do you do most of the day in your job postures, positions and repetitive movements? _____

 On a scale of 0-10 (0 = Worst and 10 = Best) rate how well you think you are doing with the following:
 Exercise _____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level _____

HEALTH HABITS

DO YOU SMOKE? YES NO
 HOW OFTEN? _____
 DO YOU DRINK ALCOHOL? YES NO
 HOW OFTEN? _____
 DO YOU DRINK COFFEE, TEA, OR SODA? YES NO
 DO YOU EXERCISE REGULARLY? YES NO
 IF YES, HOW OFTEN? _____
 IF NO, IS THAT SOMETHING YOU'D LIKE TO IMPROVE? _____
 DO YOU WEAR: ARCH SUPPORTS HEEL LIFTS SOLE LIFTS INSOLES

REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days:

- 0 = Never have this symptom
- 1 = Occasionally have this symptom, effect not severe
- 2 = Occasionally have this symptom, effect is severe
- 3 = Frequently have this symptom, effect not severe
- 4 = Frequently have this symptom, effect is severe

Head: <input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia	Energy / Activity: <input type="checkbox"/> Fatigue / Sluggishness <input type="checkbox"/> Apathy / Lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness	Lungs: <input type="checkbox"/> Chest Congestion <input type="checkbox"/> Asthma, Bronchitis <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Difficulty Breathing
Eyes: <input type="checkbox"/> Watery or Itchy Eyes <input type="checkbox"/> Swollen, Red or Sticky Eyelids <input type="checkbox"/> Bags or Dark Circles Under Eyes <input type="checkbox"/> Blurred or Tunnel Vision (not including near or far sightedness)	Weight: <input type="checkbox"/> Binge Eating / Drinking <input type="checkbox"/> Craving Certain Foods <input type="checkbox"/> Excessive Weight <input type="checkbox"/> Compulsive Eating <input type="checkbox"/> Water Retention <input type="checkbox"/> Underweight	Heart: <input type="checkbox"/> Irregular or Skipped Heartbeat <input type="checkbox"/> Rapid or Pounding Heartbeat <input type="checkbox"/> Chest Pain
Ears: <input type="checkbox"/> Itchy Ears <input type="checkbox"/> Earaches, Ear Infections <input type="checkbox"/> Drainage from Ear <input type="checkbox"/> Ringing in Ears, Hearing Loss	Emotions: <input type="checkbox"/> Mood Swings <input type="checkbox"/> Anxiety / Fear / Nervousness <input type="checkbox"/> Anger / Irritability / Aggressiveness <input type="checkbox"/> Depression	Digestive Tract: <input type="checkbox"/> Nausea, Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating Feeling <input type="checkbox"/> Belching, Passing Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Intestinal / Stomach Pain
Nose: <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Hay Fever <input type="checkbox"/> Sneezing Attacks <input type="checkbox"/> Excessive Mucus Formation	Mind: <input type="checkbox"/> Poor Memory <input type="checkbox"/> Confusion, Poor Comprehension <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Poor Physical Condition <input type="checkbox"/> Difficulty Making Decisions <input type="checkbox"/> Stuttering or Stammering <input type="checkbox"/> Slurred Speech	Mouth and Throat: <input type="checkbox"/> Chronic Coughing <input type="checkbox"/> Frequent Need to Clear Throat <input type="checkbox"/> Sore Throat, Hoarseness <input type="checkbox"/> Swollen or Discolored Tongue <input type="checkbox"/> Canker Sores
Skin: <input type="checkbox"/> Acne <input type="checkbox"/> Hives, Rashes, Dry Skin <input type="checkbox"/> Hair Loss <input type="checkbox"/> Flushing, Hot Flashes <input type="checkbox"/> Excessive Sweating	Joints / Muscles: <input type="checkbox"/> Pain or Aches in Joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or Limited Movement <input type="checkbox"/> Pain or Aches in Muscles <input type="checkbox"/> Weakness or Fatigued Muscles	Other: <input type="checkbox"/> Frequent Illness <input type="checkbox"/> Frequent or Urgent Urination <input type="checkbox"/> Genital Itch or Discharge
GRAND TOTAL:		