Life Wellness Center

LWC

10551 165th St. W. Lakeville, MN 55044 952-435-5300
1895 Plaza Dr. Suite 200 Eagan, MN 55122 651-688-8886

Date: _____

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ City _____ State _____

Zip _____ Birth date _____/_____/_____ Age _____ Sex [ ] Male [ ] Female [ ] Rather not answer

Home phone _____ Cell phone _____

Email address _____ Social Security Number _____

[ ] Married [ ] Single [ ] Minor [ ] Widowed [ ] Divorced [ ] Separated [ ] Partnered

Spouse's Name _____

Patient's Employer/School _____ Occupation _____

Whom may we thank for referring you? _____

In Case of Emergency, Contact:

Name _____Contact Number _____

Relationship _____

Insurance Information

Insurance Carrier _____ Policy Number _____

Group Number_____ Policy Holder _____

Policy Holder's DOB _____ Relationship to Policy Holder _____

Is your condition due to a recent auto accident or work related injury? [ ] Yes [ ] No

If so, [ ] Auto or [ ] Work

Current Health Concerns

What symptoms prompted you to seek care today:

_____

_____

When did your symptoms appear and how often do you feel it? _____

_____

Is this condition getting progressively worse? [ ] Yes [ ] No

Intensity of pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain: [ ] Sharp [ ] Dull [ ] Throbbing [ ] Numbness [ ] Aching [ ] Shooting

[ ] Burning [ ] Tingling [ ] Cramps [ ] Stiffness [ ] Swelling

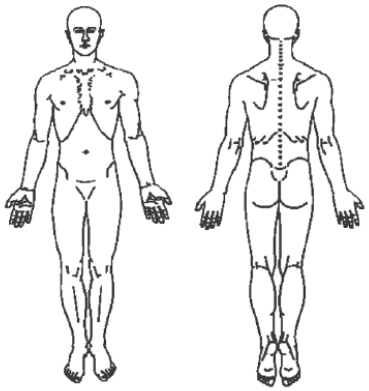
How often do you have this pain? _____

What worsens the problem? _____ Lessens the problem? _____

Activities or movements that are painful to perform: [ ] Sitting [ ] Standing [ ] Walking

[ ] Bending [ ] Lying Down [ ] Lifting [ ] Other _____

Please mark on the diagram where you have symptoms



What else would you like Life Wellness Center to know about your condition?

_____

Are you currently receiving treatment for any healthcare conditions? [ ] Medications [ ] Surgery [ ] Chiropractic

[ ] Physical Therapy [ ] None [ ] Other _____

Name and location of other doctor(s) who have treated you for your condition

_____

Date of Last Imaging (xray, MRI, CT) _____

Any other injuries/surgeries you've had: _____

Are you pregnant? [ ] Yes [ ] No Due Date _____

Provider Signature _____

Health History

Place a mark to indicate if you have had any of the following:

[ ] AIDS/HIV
[ ] Alcoholism
[ ] Allergy Shots
[ ] Anemia
[ ] Anorexia
[ ] Appendicitis
[ ] Arthritis
[ ] Asthma
[ ] Bleeding Disorders
[ ] Breast Lump
[ ] Bronchitis
[ ] Bulimia
[ ] Cancer
[ ] Cataracts
[ ] Chemical Dependency
[ ] Chicken Pox
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Fractures
[ ] Glaucoma
[ ] Goiter
[ ] Gout
[ ] Heart Disease
[ ] Hepatitis
[ ] Hernia
[ ] Herniated Disc
[ ] Herpes
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Kidney Disease
[ ] Liver Disease
[ ] Measles
[ ] Migraines
[ ] Miscarriage
[ ] Mononucleosis
[ ] Multiple Sclerosis
[ ] Mumps
[ ] Osteoporosis
[ ] Pacemaker
[ ] Parkinson's Disease
[ ] Pinched Nerve
[ ] Pneumonia
[ ] Polio
[ ] Prostate Problem
[ ] Prosthesis
[ ] Psychiatric Care
[ ] Rheumatoid Arthritis
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Stroke
[ ] Suicide Attempt
[ ] Thyroid Problem
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Tumor, Growth
[ ] Typhoid Fever
[ ] Ulcers
[ ] Venereal Disease
[ ] Whooping Cough

[ ] Other _____

Exercise:
[ ] Daily
[ ] Weekly
[ ] None

Habits:
[ ] Smoking
[ ] Alcohol
[ ]Coffee/Caffeine

Work Activity:
[ ]Sitting
[ ] Standing
[ ] Light labor
[ ] Heavy labor

Family History

	Healthy?	Illnesses?	Age at Death
Mother	[] Yes []No	_____	_____
Father	[] Yes []No	_____	_____
Sister	[] Yes []No	_____	_____
Sister	[] Yes []No	_____	_____
Brother	[] Yes []No	_____	_____
Brother	[] Yes []No	_____	_____

ACKNOWLEDGEMENTS

☐ I instruct the provider to deliver the care, that in their professional judgement, can best help me in the restoration of my health. I understand that the care offered in this practice is based on the best available evidence the providers find in their examinations.

☐ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf.

☐ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.

☐ I grant permission to be called to confirm or reschedule an appointment, and be sent occasional cards, letters, emails, or health information to me as an extension of care in this office.

☐ I acknowledge that any insurance I may have is an agreement between the carrier and me, and that I am responsible for the payment of any covered or non-covered services I receive at Life Wellness Center.

☐ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concerns.

If the patient is a minor child, print child's full name: _____

Signature _____ Date _____

Provider Signature _____