

Last Name:



5550 S. 59<sup>th</sup> Ste. 14  
Lincoln, Ne 68516  
Lincolnchiropracticwellness.com

## Welcome to Lincoln Chiropractic Wellness

Welcome to our office! Rest assured that you will be provided the most appropriate and professional healthcare possible. Our most important goal is the constant improvement and maintenance of your health. Before we get started with your examination procedures, which will determine if we can help you, we want you to understand what we do and why we are going to do it.

When a person seeks our care and when we accept a patient for such care, it is essential that they are both working towards the same goals. The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. Most importantly, you must understand that our care is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness and disease care and is necessary in emergency situations. Our approach recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is how we define healthcare; focusing on the optimum function of the individual, and it is what we do it in our office.

We provide various services in our office including Chiropractic care, massage therapy, exercise therapy and nutritional services. The purpose of Chiropractic care is to restore and maintain the integrity of the spine, spinal cord and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine call vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interference (pinched nerve) and cause dysfunction to the tissue and organs that these nerves supply. With appropriate Chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nerve system is the foundation to good health.

The information we get from you on the following pages is important. For this reason, please fill out our history forms completely and to the best of your ability so that we can quickly get you on the road to health. We look forward to a healthy relationship with you and your family.

I, \_\_\_\_\_, have read the above, understand it.

Last Name: \_\_\_\_\_



Date: \_\_\_\_\_ Social Security # \_\_\_\_\_

Name: \_\_\_\_\_  
Last First M.I

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail (please provide for communication purposes) \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

\_\_\_\_ Married \_\_\_\_ Separated \_\_\_\_ Widowed \_\_\_\_ Divorced \_\_\_\_ Single \_\_\_\_ Partnered for \_\_\_\_ Yrs \_\_\_\_ Minor

Preferred method of communication: (Check one) Email \_\_\_\_ Text \_\_\_\_ + Carrier Name \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino/ Decline

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

Patient Employer/School \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone \_\_\_\_\_

**ACCIDENT INFORMATION:** Is condition due to an accident? Yes \_\_\_\_ No \_\_\_\_ Date of Accident \_\_\_\_\_  
Type of Accident: Auto \_\_\_\_ Work \_\_\_\_ Home \_\_\_\_ Other \_\_\_\_

**INSURANCE INFORMATION:**

Who is responsible for this account? \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ 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. Justin Steinhauser 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 the use of my signature on all insurance submissions.

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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. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative Date

\_\_\_\_\_  
Please print name of above signature Relationship to Patient

### Financial Responsibility

**Patient Name** \_\_\_\_\_

Dear Patient,  
Lincoln Chiropractic Wellness provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. **In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.**  
I have read and understood all the above information.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### X-Ray Consent

I hereby give my consent to Lincoln Chiropractic Wellness and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.  
I have read and understood all the above information.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Last Name:



Last Name: \_\_\_\_\_

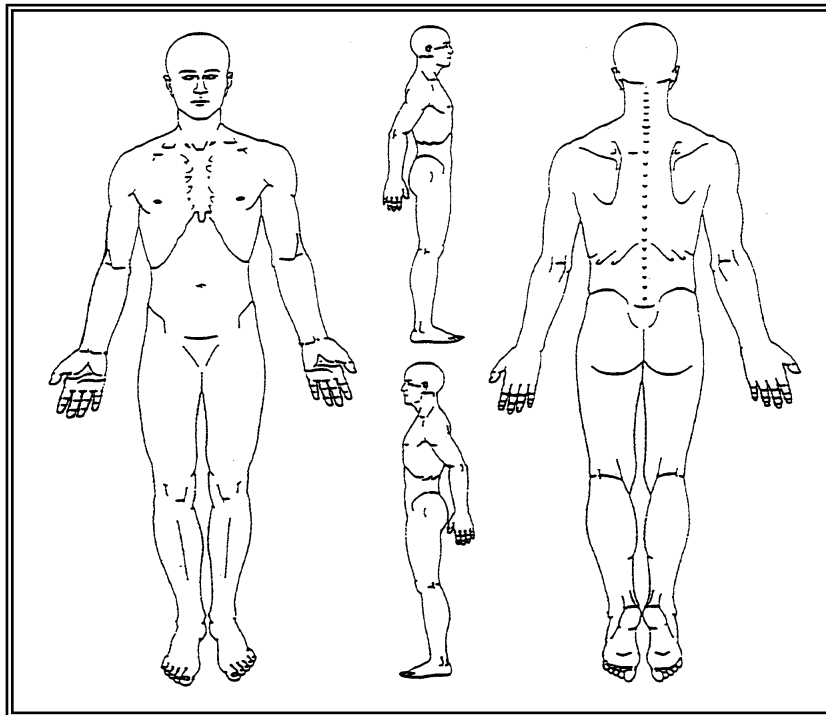


Please let us know who we can thank for referring you to our office: \_\_\_\_\_

Please indicate the main reason you are seeing us today: \_\_\_\_\_

If you are seeing us for a pain related issue, use the symbols to show what type of pain you feel on the diagram.

XXXXXXXXX    // // // // // //    O O O O O O O O O    S S S S S    - - - - -  
DULL/ACHY    SHARP/STABBING    NUMBNESS/TINGLING    STIFF/TIGHT    BURNING



Using the pain scale below, circle the pain level you experience when this problem is at its very worst:

- 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.

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Do you have any other health conditions, regardless of whether you think it's related to your spine:

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

Is there any radiating pain into the arms or legs? \_\_\_\_\_ Is there any numbness or tingling? \_\_\_\_\_

How long have you been suffering with this problem, has it been more than a month or two? \_\_\_\_\_

When was the first time you EVER recall having a problem in this area? \_\_\_\_\_

How often have you suffering with this problem? (Please indicate for each of the body area of concern)

Constant (75 – 100% of the time) \_\_\_\_\_ Frequent (50 – 75% of the time) \_\_\_\_\_

Occasional (25 – 50% of the time) \_\_\_\_\_ Intermittent (0 – 25% of the time) \_\_\_\_\_

Every trauma is recorded in the spine. Please give a brief description of any significant injuries or accidents over the course of your life (slips, falls, injuries, car accidents) , whether or not you think they are related to your spine:

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

Did you go to the hospital for any of these injuries? \_\_\_\_\_

Did you get any X-rays for any of these injuries? \_\_\_\_\_

Did you get checked by a Chiropractor after any of these injuries? \_\_\_\_\_

List any MD's or Chiropractors you've already seen for your current problem:

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

What tests have you already had for this problem? X-rays MRI C.T. Scan Myelogram EMG/NCV

None Other \_\_\_\_\_

What have you already tried for this problem? Anti-inflammatory Pain Meds Muscle Relaxers

Injections Physical Therapy Chiropractic Massage Exercise Other \_\_\_\_\_

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 \_\_\_\_\_

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What activity does this problem prevent you from doing, either partially or totally, that you would really like to be able to do again? \_\_\_\_\_

What area of your life has this problem affected the most? Family Relationships Work Exercise Recreation

On a scale of 1 to 10, with 10 being the highest, rate your level of commitment to get rid of this problem: \_\_\_\_\_

Please list any concerns you may have about getting this problem corrected such as time or transportation: \_\_\_\_\_

### REVIEW OF SYMPTOMS

Please use the 0 to 4 guide below to rate each of the symptoms on this page according to your health status over the past 30 days.

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

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

### MEDICATIONS & ALLERGIES

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

List any medications you are taking: \_\_\_\_\_

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### FAMILY HISTORY

**Mother:** Living Deceased List any medical problems: \_\_\_\_\_

**Father:** Living Deceased List any medical problems: \_\_\_\_\_

**List any problems common in your family:** Cancer Diabetes Heart disease High blood pressure Stroke Arthritis  
Scoliosis Thyroid disease Osteoporosis Other \_\_\_\_\_

### SOCIAL HISTORY

**Do you have any children?** Yes No If yes, how many? \_\_\_\_\_

**Do you drink alcohol?** Yes No If yes, how much & how often? \_\_\_\_\_

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

### PERSONAL HEALTH GOALS

<input type="checkbox"/> Improve Nutrition/Eating Habits	<input type="checkbox"/> Lower Cholesterol	<input type="checkbox"/> Get off Medications
<input type="checkbox"/> Weight Loss/Fat Loss	<input type="checkbox"/> Lower Blood Pressure	<input type="checkbox"/> Improved Sleep
<input type="checkbox"/> Increase Lean Muscle Mass	<input type="checkbox"/> Start Exercising	<input type="checkbox"/> Improved Energy
<input type="checkbox"/> Increase Bone Density	<input type="checkbox"/> Look Better	<input type="checkbox"/> Improved Posture
<input type="checkbox"/> Reduce Stress	<input type="checkbox"/> Feel Better	<input type="checkbox"/> Improved Outlook/Happiness

**On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you are doing in the following categories:**

**Exercise** \_\_\_\_\_ **Sleep** \_\_\_\_\_ **Diet** \_\_\_\_\_ **Stress Level** \_\_\_\_\_ **Water Intake** \_\_\_\_\_ **Energy Level** \_\_\_\_\_

**Do you take: Omega 3 (Fish Oil)?** Yes No      **Vitamin D3?** Yes No      **Probiotics?** Yes No

**Who is your Family Physician or Primary Doctor that monitors you?** \_\_\_\_\_

**When was the last time you had blood work done?** \_\_\_\_\_



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### Medical Symptoms Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for:

Past 30 days

Point Scale    0 - Never or almost never have the symptom  
                  1 - Occasionally have it, effect is not severe  
                  2 - Occasionally have it, effect is severe  
                  3 - Frequently have it, effect is not severe  
                  4 - Frequently have it, effect is severe

HEAD            \_\_\_\_\_ Headaches  
                  \_\_\_\_\_ Sinus Problems  
                  \_\_\_\_\_ Dizziness  
                  \_\_\_\_\_ Insomnia  
Total            \_\_\_\_\_

NOSE           \_\_\_\_\_ Stuffy Nose  
                  \_\_\_\_\_ Gagging, Frequent Need to Clear Throat  
                  \_\_\_\_\_ Hay Fever  
                  \_\_\_\_\_ Excessive Mucus Formation  
Total            \_\_\_\_\_

EYES            \_\_\_\_\_ Watery or itchy  
                  \_\_\_\_\_ Swollen, Reddened or Sticky eyelids  
                  \_\_\_\_\_ Bags or Dark circles under eyes  
                  \_\_\_\_\_ Blurred or Tunnel Vision  
(doesn't included near or far-sighted)  
Total            \_\_\_\_\_

EARS            \_\_\_\_\_ Itchy Ears  
                  \_\_\_\_\_ Earaches, Ear Infections  
                  \_\_\_\_\_ Drainage from ear  
                  \_\_\_\_\_ Ringing in Ears, Hearing loss  
Total            \_\_\_\_\_

MOUTH/THROAT \_\_\_\_\_ Chronic Coughing  
                  \_\_\_\_\_ Faintness  
                  \_\_\_\_\_ Sore Throat, Hoarseness, Loss of Voice  
                  \_\_\_\_\_ Swollen or Discolored Tongue, Gums, or Lips  
                  \_\_\_\_\_ Canker Sores  
Total            \_\_\_\_\_

SKIN            \_\_\_\_\_ Acne  
                  \_\_\_\_\_ Hives, Rashes, Dry Skin  
                  \_\_\_\_\_ Hair Loss  
                  \_\_\_\_\_ Flushing, Hot Flashes  
                  \_\_\_\_\_ Excessive Sweating  
Total            \_\_\_\_\_

HEART           \_\_\_\_\_ Irregular or Skipped Heartbeat  
                  \_\_\_\_\_ Rapid or Pounding Heartbeat  
                  \_\_\_\_\_ Chest Pain  
Total            \_\_\_\_\_

LUNGS           \_\_\_\_\_ Chest Congestion  
                  \_\_\_\_\_ Asthma, Bronchitis  
                  \_\_\_\_\_ Shortness of Breath  
                  \_\_\_\_\_ Difficulty Breathing  
Total            \_\_\_\_\_

Last Name: \_\_\_\_\_



DIGESTIVE TRACT

- \_\_\_\_\_ Nausea, Vomiting
- \_\_\_\_\_ Diarrhea
- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Bloating Feeling
- \_\_\_\_\_ Belching, Passing Gas
- \_\_\_\_\_ Heartburn
- \_\_\_\_\_ Intestinal/Stomach Pain
- Total \_\_\_\_\_

JOINTS/MUSCLE

- \_\_\_\_\_ Pain or Aches in Joints
- \_\_\_\_\_ Arthritis
- \_\_\_\_\_ Stiffness or Limitation of Movement
- \_\_\_\_\_ Pain or Aches in Muscles
- \_\_\_\_\_ Feeling of Weakness or Tiredness
- Total \_\_\_\_\_

WEIGHT

- \_\_\_\_\_ Binge Eating/Drinking
- \_\_\_\_\_ Craving Certain Foods
- \_\_\_\_\_ Excessive Weight
- \_\_\_\_\_ Compulsive Eating
- \_\_\_\_\_ Water Retention
- \_\_\_\_\_ Underweight
- Total \_\_\_\_\_

ENERGY/ACTIVITY

- \_\_\_\_\_ Fatigue, Sluggishness
- \_\_\_\_\_ Apathy, Lethargy
- \_\_\_\_\_ Hyperactivity
- \_\_\_\_\_ Restlessness
- Total \_\_\_\_\_

MIND

- \_\_\_\_\_ Poor Memory
- \_\_\_\_\_ Confusion, Poor Comprehension
- \_\_\_\_\_ Poor Concentration
- \_\_\_\_\_ Poor Physical Condition
- \_\_\_\_\_ Difficulty in Making Decisions
- \_\_\_\_\_ Stuttering or Stammering Total \_\_\_\_\_
- \_\_\_\_\_ Slurred Speech
- \_\_\_\_\_ Learning Disabilities
- Total \_\_\_\_\_

EMOTIONS

- \_\_\_\_\_ Mood Swings
- \_\_\_\_\_ Anxiety, Fear, Nervousness
- \_\_\_\_\_ Anger, Irritability, Aggressiveness
- \_\_\_\_\_ Depression
- Total \_\_\_\_\_

OTHER

- \_\_\_\_\_ Frequent Illness
- \_\_\_\_\_ Frequent or Urgent Urination
- \_\_\_\_\_ Genital Itch or Discharge
- Total \_\_\_\_\_

Last Name:



GRAND TOTAL \_\_\_\_\_