Last Name:

5550 S. 59th 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.

Last Name:

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

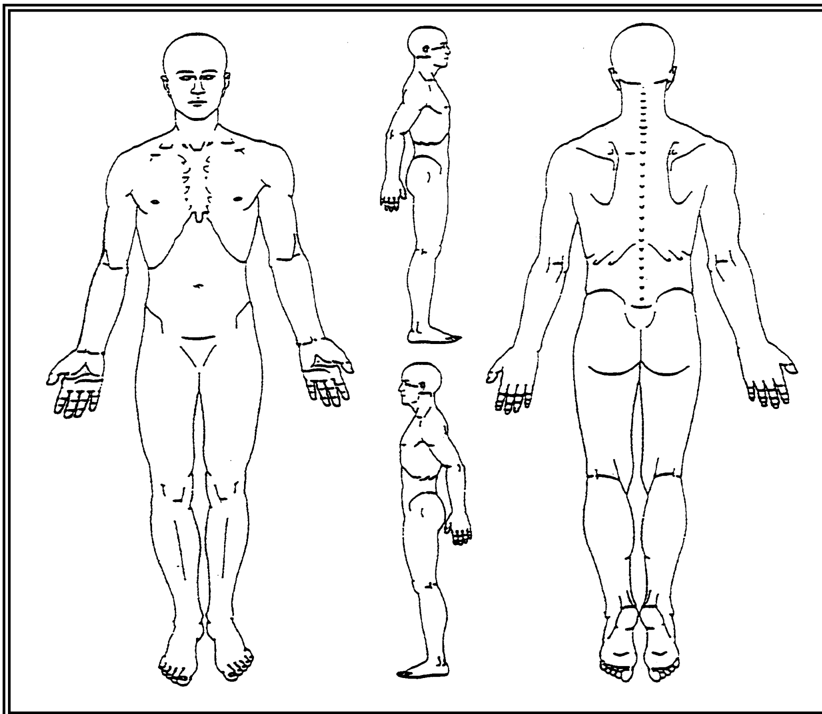
Last Name:

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 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.

Last Name:

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 do you do most of the day in your job postures, positions and repetitive movements:______________________

____

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 <u>worse</u>? ☐Sitting ☐Standing ☐Changing Position ☐Walking ☐Bending ☐Lifting ☐Twisting
☐Reaching ☐Driving ☐Sleeping ☐Sneeze/Cough ☐Computer Work ☐Telephone ☐Going From Sit to Stand
☐Other____

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

Last Name:

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: ____

____

Last Name:

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

☐Improve Nutrition/Eating Habits	☐Lower Cholesterol	☐Get off Medications
☐Weight Loss/Fat Loss	☐Lower Blood Pressure	☐Improved Sleep
☐Increase Lean Muscle Mass	☐Start Exercising	☐Improved Energy
☐Increase Bone Density	☐Look Better	☐Improved Posture
☐Reduce Stress	☐Feel Better	☐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? ____

Last Name:

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
_______ Bloated 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 _______

GRAND TOTAL ________