Lifetime Wellness Center

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www.lifetimewellnesscentre.com

Welcome to our office!

To ensure your visit with us is a pleasant one, here are the procedures you can expect during the next 30 minutes.

Paperwork	Complete this brief questionnaire and your health form to help us get to know you.
Consultation	You will meet the Doctor and/or our New Patient Advocate. We will take your health history and determine if yours is a Low Level Laser Therapy case.
Examination	Standard physical, orthopedic, neurological tests will be performed to determine the cause(s) of your health concerns.
Laser Treatment Plan	If you are a candidate for Low Level Laser Therapy, treatment can be started immediately. You will be informed of your plan for care, including the recommended number of visits during your initial visit.

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CONFIDENTIAL PATIENT HISTORY-GENERAL INFORMATION

☐Miss ☐Mrs. ☐Ms ☐Mr. Name: _____ **Date:** _____

Address: _____ **City**: _____ **Postal Code:** _____

Home Ph: _____ **Mobile Ph:** _____ **Bus Ph**: _____

Email: _____ **Date of Birth:** d_____/m_____/y_____ **Age:** _____ **Sex: ☐M ☐F**

Occupation/Profession: _____ **Employed by:** _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed **Number of Children:** _____

Medical Doctor/Specialists: _____

Extended Coverage: ☐No ☐Yes **Benefit Company:** _____

Significant Other's Insurance Information: Benefit Company: _____

What is your major/minor complaint for which you are seeking Low Level Laser Therapy?

_____

_____

OFFICE USE ONLY

Referral Source: _____ Have you had Low Level Laser Therapy before? Y/N
Previous Chiropractor:_____ Last Adjustment: _____ Frequency: _____
Technique Used: ☐Manual ☐Drop Piece ☐Activator Preference: _____

Specific Insurance Information (please note that we do not directly bill to your insurance companies)

Chiropractic Coverage: _____ Massage Therapy Coverage: _____
Naturopathic Coverage: _____ Orthotic Coverage: _____

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage and help us determine your plan for recovery.

PRESENT HEALTH: Are you presently affected by any of the following? (Within 3 months)

O – Occasional F – Frequent C – Constant

MUSCLE AND JOINT	O	F	C
Backache	☐	☐	☐
Neck pain	☐	☐	☐
Painful tailbone	☐	☐	☐
Foot trouble	☐	☐	☐
Shoulder pain	☐	☐	☐
Hernia	☐	☐	☐
Spinal curvature	☐	☐	☐
Faulty posture	☐	☐	☐
Arthritis	☐	☐	☐

STRESS SYMPTOMS			
Headache/Migraine	☐	☐	☐
Dizziness	☐	☐	☐
Numbness in arms/hand	☐	☐	☐
Numbness in foot/leg	☐	☐	☐
Ringing in ears	☐	☐	☐
Blurring of vision	☐	☐	☐
Loss of sleep	☐	☐	☐
Loss of concentration	☐	☐	☐
Loss of memory	☐	☐	☐
Irritable/Nervous	☐	☐	☐
Depression	☐	☐	☐
Decreased energy	☐	☐	☐
Fatigue	☐	☐	☐
Tension	☐	☐	☐

GENERAL SYMPTOMS	O	F	C
Fever, chills, sweats	☐	☐	☐
Fainting	☐	☐	☐
Convulsions	☐	☐	☐
Allergy	☐	☐	☐
Skin problems	☐	☐	☐
Colds	☐	☐	☐
Tremors	☐	☐	☐
Loss of balance	☐	☐	☐

RESPIRATORY			
Chronic cough	☐	☐	☐
Spitting up phlegm/blood	☐	☐	☐
Chest pain	☐	☐	☐
Difficult breathing	☐	☐	☐

URINARY			
Painful urination	☐	☐	☐
Waking at night to urinate	☐	☐	☐
Blood in urine	☐	☐	☐
Increased urination	☐	☐	☐

GASTROINTESTINAL	O	F	C
Difficult digestion	☐	☐	☐
Belching or gas	☐	☐	☐
Nausea or vomiting	☐	☐	☐
Pain over stomach	☐	☐	☐
Constipation	☐	☐	☐
Colon trouble	☐	☐	☐
Liver trouble	☐	☐	☐
Gall bladder trouble	☐	☐	☐
Heartburn	☐	☐	☐
Diarrhea	☐	☐	☐
Bloody stools	☐	☐	☐

EYES, EARS, NOSE, THROAT			
Deafness	☐	☐	☐
Earache	☐	☐	☐
Sore throat	☐	☐	☐
Asthma	☐	☐	☐
Tonsillitis	☐	☐	☐
Sinus trouble	☐	☐	☐

CARDIOVASCULAR	O	F	C
Rapid heart beat	☐	☐	☐
Slow heart beat	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Pain over heart	☐	☐	☐
Swelling of ankles	☐	☐	☐
Previous heart attack	☐	☐	☐
Poor circulation	☐	☐	☐
Previous stroke	☐	☐	☐

FEMALES ONLY	
Painful menstruation	☐ ☐ ☐
Excessive flow	☐ ☐ ☐
Irregular	☐ ☐ ☐
Cramps or backache	☐ ☐ ☐
Abnormal discharge	☐ ☐ ☐
Passed menopause	☐Y ☐N
Are you pregnant	☐Y ☐N
Birth control pill	☐Y ☐N

No. of miscarriages _____

Date of last menstrual period

Smoker Y/N
Former Smoker __ # years?

PAST HEALTH: Have you ever suffered from any of the following conditions?

	Yes	No
Thyroid trouble	☐	☐
Diabetes	☐	☐
High blood pressure	☐	☐
Heart disease	☐	☐
Allergies	☐	☐

	Yes	No
Tuberculosis	☐	☐
Pneumonia	☐	☐
Back pain	☐	☐
Headaches	☐	☐
Stomach ulcers	☐	☐

	Yes	No
Emotional problems	☐	☐
Epileptic seizures	☐	☐
Asthma	☐	☐
Arthritis	☐	☐
Alcoholism	☐	☐

	Yes	No
Psoriasis	☐	☐
Polio	☐	☐
Cancer	☐	☐
Venereal Disease	☐	☐
HIV	☐	☐

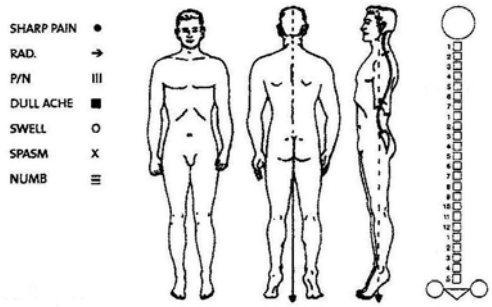
Please list any significant illness, operations, accidents, falls, or traumas

DATE	Illness / Operation / Accident / Falls

Please list any medications and or supplements that you are currently taking

Medication/Supplement	Dosage ,Length of time taken, and Reason for use

OFFICE USE ONLY

COMPLAINTS	PRIMARY	SECONDARY	
HISTORY OF CONDITION - **Onset** - **Location** - **Progression** - **Prior Occ.** - **Worse** - **Interference** - **Work** - **Family**			**SLEEP** **Position: ☐Side ☐Back ☐Stomach ☐All** **Orthotic pillow: ☐Yes ☐No** **Pain:** **Area of Complaint** 
PAIN - **Character** - **Radiation** - **Frequency** - **Duration** - **Association** - **1 to 10** - **Lifestyle**		**TRAUMA**	
AGGRAVATING FACTORS			
RELIEVING FACTORS		**STRESS 1 to 10**	

Up-Regulation

Nerve Root	Strong/Weak
Peroneal-S1	S/W
Hallic Longus- L5	S/W
Tibialis -L4	S/W
Hip Flexion- L1-2	S/W
Knee Ext-L4	S/W
Hamstring-S1	S/W

Nerve Root	Strong/Weak
Flex/ext-C1	S/W
R&L Lat Flex-C3	S/W
R&L Rotation-C4	S/W

Nerve Root	Strong/Weak
Finger Flare-T1	S/W
Finger Flexion - C8	S/W
Tricep-C7	S/W
Bicep-C6	S/W
Deltoid- C5	S/W

LIFESTYLE GOALS/SUGGESTIONS

DATE	AREA TREATED	PROTOCOL	FINDINGS	TIME (min)

INFORMED CONSENT TO LASER THERAPY

As is true of many alternative therapies, you may receive alternative benefits to being treated in addition to what you wanted initially. Although, the list of symptoms responding to the Low Level Laser is growing, we do not claim to cure any disease or ailment.

Contraindications to Laser Therapy

- Although there is no conclusive research to substantiate not treating patients with pacemakers and or vagal stimulation device, the manufacturer recommends not treating such patients. There is no documentation or reason not to treat patients with other implants.

- Also, there is no contraindicative research against treating pregnant women, the manufacturer suggests to avoid treating pregnant women.

Reactions to Treatment

- Occasionally, some patients may suffer a slight increase in pain. This is not necessarily an adverse reaction and may be a consequence if increased blood flow, or change in metabolic activity occurs within 24-48 hours of treatment.

Consent to Treatment

I acknowledge that I have read and discussed, with my laser therapist, the nature and purpose of the Low Level Laser and my treatment in particular. I understand that symptoms of any kind are a result of abnormal cell function. The Low Level Laser has been shown to return cells to their normal function. Once cells heal, further treatment is usually not necessary, unless the area is re-injured.

I consent to the recommendations and future treatments suggested by Dr. Michelle Prince, DC, and the Low Level Laser staff of Lifetime Wellness Center, and I accept the responsibility for all fees (paid in full, or unless other arrangements have been made) incurred by myself, or the patient that I am a guardian over .

Name of Patient _____
\Signature _____
Date signed _____

Thank you for completing this form. We look forward to assisting you achieve your optimal health.

Consent to the Collection, Use, and Disclosure of Personal Information

NOTE TO CLIENT: In accordance with the privacy act effective January 2004, we must ask for your informed consent. This means we want you to understand what we do with personal information. Your signature below allows us to obtain this information to open a confidential file for you. This is the only reason we collect your personal information.

I understand that to provide me with any recommendations for my health, Lifetime Wellness Center will collect some personal information about me (e.g.: telephone number, birth date, address, etc.).

We use and disclose your personal health information to:

- treat and care for you,
- plan, administer and manage our internal operations,
- conduct quality improvement activities (such as sending patient satisfaction surveys)
- teach,
- compile statistics,
- comply with legal and regulatory requirements, and
- fulfill other purposes permitted by law.

We take steps to protect your personal health information from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal. We conduct audits and complete investigations to monitor and manage our privacy compliance. We take steps to ensure that everyone who performs services for us protect your privacy and only use your personal health information for the purpose you have consented to.

I understand that only if I check off the following statement I will *NOT* receive the following:

☐ Newsletters and other informational emails from Lifetime Wellness Center

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to the commitments.

I agree to Lifetime Wellness Center collecting, using and disclosing personal information about me as set out and in the Lifetime Wellness Center's Privacy Policy.

Patient/Guardian Signature: _____ Date: _____

Patient's printed name: _____

Website Membership Enrollment

The information on our website will help you

GET WELL and STAY WELL!

Please provide the following details so we can establish you as a member of our website today.

Name (First and Last): _____

Date of Birth: _____ / _____ /_____

Email Address: _____

Please check the health subject(s) that most interest you:

- ☐ *Headaches and Neck Pain*
- ☐ *Backaches and Sciatica*
- ☐ *Children's Health*
- ☐ *Women's Health*
- ☐ *Wellness Topic*
- ☐ *Diet Nutrition*
- ☐ *Exercise and Fitness*
- ☐ *Stress Management*

By joining our website, you are authorizing us to send you occasional health care related emails. Naturally, you may opt-out at any time. We never share your information.

Yours in Health,

Dr. Michelle Prince