LAZARUS WELLNESS
Functional Medicine • Clinical Nutrition
Spinal Therapy • Fitness & Rehabilitation

CONFIDENTIAL
New Patient Information

First Name: | MI | Last Name: | ☐ Male ☐ Female | Date of Birth: | Age:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Number of Children:

Main Insured First Name: | MI | Last Name: | ☐ Male ☐ Female | Date of Birth: | Age:

Home Address: | City: | State: | Zip:

Home Phone Number: | Work Phone Number: | E-mail Address:

Employer Name: | Years Employed:

Work Address: | City: | State: | Zip:

HEALTH QUESTIONNAIRE & OVERVIEW

If you have ever had a symptom in the past, please list that symptom in the **Past Column**.
If you are presently troubled by a particular symptom, check that symptom in the **Present Column**.

~KNOWLEDGE OF ANY OF THE FOLLOWING INFORMATION MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE~

Past	Present	Condition
☐	☐	Neck Pain
☐	☐	Shoulder Pain (R__ L__)
☐	☐	Pain in Upper Arm or Elbow (R__ L__)
☐	☐	Hand Pain (R__ L__)
☐	☐	Wrist Pain (R__ L__)
☐	☐	Upper Back Pain (R__ L__)
☐	☐	Lower Back Pain (R__ L__)
☐	☐	Pain in Upper Leg or Hip (R__ L__)
☐	☐	Pain in Lower Leg or Knee (R__ L__)
☐	☐	Pain in Ankle or Foot (R__ L__)
☐	☐	Jaw Pain (R__ L__)
☐	☐	Headache
☐	☐	Swelling, Stiffness of Joint(s)

Past	Present	Condition
☐	☐	High Blood Pressure
☐	☐	Aortic Aneurysm
☐	☐	Heart Attack (Date: _____)
☐	☐	Stroke (Date: _____)
☐	☐	Asthma
☐	☐	Cancer, Explain
☐	☐	Prostate Disorders, Explain
☐	☐	Blood Disorder
☐	☐	Emphysema (Chronic Lung Disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes, Type: _____
☐	☐	Ulcer
☐	☐	Liver/Gallbladder Conditions
☐	☐	Hepatitis, Type: _____
☐	☐	Bladder Infection
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS

Past	Present	Condition
☐	☐	Fainting, Visual Disturbances, Dizziness
☐	☐	Convulsions
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Depression
☐	☐	Painful or Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/Irregular bowel habits
☐	☐	Heartburn/Indigestion
☐	☐	Difficulty in Swallowing
☐	☐	Dermatitis/Eczema/Rash

Past	Present	Condition *(This box is for women only)*
☐	☐	Menstrual Flow: ☐ Irregular ☐ Profuse
☐	☐	Breast ☐ Soreness ☐ Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Pregnancy, # Births: _____
☐	☐	Birth Control Pills, Type: _____
☐	☐	Breast Implants/Augmentation

YES	NO	
☐	☐	Do you have permanent Disability Rating?
☐	☐	Where: _____
☐	☐	Date rating received: ____ /____ /_____
☐	☐	Rating Percentage: _____ %

HEALTH QUESTIONNAIRE CONTINUED . . .

The following lists a variety of conditions that patients may experience.
Please read through the following list and check the box next to each condition, if it applies to you.

- ☐ Neck pain with difficulty swallowing.
- ☐ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck.
- ☐ Leg pain that worsens with exercise but is relieved by resting.
- ☐ Loss of feeling in inner thighs.
- ☐ Back pain with urinary problems.
- ☐ Severe pain that interrupts sleep.
- ☐ Constant pain that does not improve by changing position or lying down.
- ☐ Recent unexplained weight loss.
- ☐ Recent progressive muscle weakness or shaking.
- ☐ Recent or current fever over 102°F.
- ☐ Loss of bowel or bladder control.
- ☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions.
- ☐ Recent major accident such as a fall from height, whiplash or blow to the head.
- ☐ Memory loss after injury.
- ☐ History of compression fracture.
- ☐ Immune suppression such as from Chemotherapy, organ transplant, etc.
- ☐ 3 or more months of steroid medication or intravenous drug use. (past or recent)

In general would you say your **overall health** right now is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

How tall are you? _____' _____" What is your **present weight**? _____ lbs.

Do you **sleep** well? ☐ YES ☐ NO What are your normal sleeping hours? _____ to _____

Do you wear **orthotics** (shoe inserts)? ☐ YES ☐ NO **If Yes**, What kind and for what reason? _____

Are you **currently under the care of a medical doctor** or other type of health care provider for any condition? ☐ YES ☐ NO

If Yes, for what condition? _____

Name of Doctor/Provider: _____ Phone: _____

Who have you seen for symptoms? ☐ No one ☐ Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other _____

What treatment (if any) did your receive? _____ Date: _____

What tests have you had for your symptoms and when were they performed?

☐ X-rays, Date: _____ ☐ MRI, Date: _____ ☐ CT Scans, Date: _____ ☐ Other, Date: _____

Have you ever had an **overnight stay in a hospital or a surgical procedure** of any kind? ☐ YES ☐ NO

If Yes, Please List Here _____ Date: _____

_____ Date: _____

Are you currently taking any **prescription medication**? ☐ YES ☐ NO

If Yes, Please List Here (1) _____ (2) _____ (3) _____

(4) _____ (5) _____ (6) _____

Please check any of the following that apply to you:

Past	Present	Condition
☐	☐	Alcohol – Drinks per week: _____
☐	☐	Drug or Alcohol dependence
☐	☐	Tobacco – Packs per Day: _____ Years: _____
☐	☐	Coffee/Tea/Caffeinated Soft drinks (cups/cans) per day: _____

FAMILY HISTORY

☐ Arthritis	☐ Cancer	☐ Chronic headaches	☐ Chronic back pain	☐ Diabetes
☐ Epilepsy	☐ Heart disease	☐ High blood pressure	☐ Kidney disease	☐ Lupus
☐ Lung problems	☐ Mental illness	☐ Osteoporosis	☐ Rheumatoid arthritis	☐ Other: _____

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COMPLAINTS/SYMPTOMS FORM

Please carefully list and explain your reason(s) for this visit in the order of importance below.

PROBLEM #1 _____ Date you first noticed: _____

PROBLEM #2 _____ Date you first noticed: _____

PROBLEM #3 _____ Date you first noticed: _____

PROBLEM #1

Location of pain: ☐ Right side ☐ Left side ☐ Both sides

During what time of the day does this feel worse? _____

Does the pain radiate to different areas? ☐ Yes ☐ No

If yes, where to: _____

How severe is the pain? (Please make an "X" on the line below)

NO PAIN ←——————→ EXTREME PAIN

During a normal day (awake hours) how frequently do you experience the pain/problem?

☐ 0 - 25 % of the time ☐ 25 - 50 % of the time
☐ 50 - 75 % of the time ☐ 75 - 100 % of the time

What makes the pain worse? _____

What relieves the pain? _____

Please explain how this problem happened:

☐ Developed over time
☐ Illness
☐ Injury
☐ Auto Accident
☐ Other
☐ I don't know

Details: _____

PROBLEM #2

Location of pain: ☐ Right side ☐ Left side ☐ Both sides

During what time of the day does this feel worse? _____

Does the pain radiate to different areas? ☐ Yes ☐ No

If yes, where to: _____

How severe is the pain? (Please make an "X" on the line below)

NO PAIN ←——————→ EXTREME PAIN

During a normal day (awake hours) how frequently do you experience the pain/problem?

☐ 0 - 25 % of the time ☐ 25 - 50 % of the time
☐ 50 - 75 % of the time ☐ 75 - 100 % of the time

What makes the pain worse? _____

What relieves the pain? _____

Please explain how this problem happened:

☐ Developed over time
☐ Illness
☐ Injury
☐ Auto Accident
☐ Other
☐ I don't know

Details: _____

PROBLEM #3

Location of pain: ☐ Right side ☐ Left side ☐ Both sides

During what time of the day does this feel worse? _____

Does the pain radiate to different areas? ☐ Yes ☐ No

If yes, where to: _____

How severe is the pain? (Please make an "X" on the line below)

NO PAIN ←——————→ EXTREME PAIN

During a normal day (awake hours) how frequently do you experience the pain/problem?

☐ 0 - 25 % of the time ☐ 25 - 50 % of the time
☐ 50 - 75 % of the time ☐ 75 - 100 % of the time

What makes the pain worse? _____

What relieves the pain? _____

Please explain how this problem happened:

☐ Developed over time
☐ Illness
☐ Injury
☐ Auto Accident
☐ Other
☐ I don't know

Details: _____

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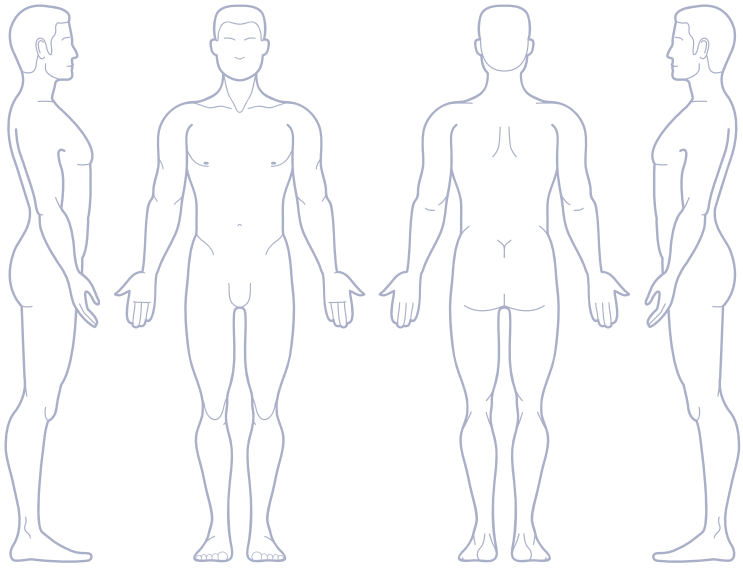
PAIN/SYMPTOM DRAWING

On the picture below, please describe your problems by drawing, circling, and making arrows to the appropriate regions. (*e.g. Numbness, pain, weakness, tingling*) Write and draw as much as you need to explain the problem(s).

+++ Sharp and stabbing pain
////// Pins and needles sensation
VVVV Dull or aching pain
oooo Numbness



How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

Please share any additional comments: _____

_____

_____

_____

How did you hear about Lazarus Wellness? _____

What do you expect to achieve from your visit and/or future visits with Dr. Ryan Lazarus, D.C./Dr. Matt Murphy, D.C.?

_____

_____

_____

- I certify that the above information is true and correct to the best of my knowledge. I agree to notify Lazarus Chiropractic, Inc. immediately whenever I have a change in my health condition.
- I consent to the release of my confidential medical and patient information in the possession of Lazarus Chiropractic, Inc, to other health care professionals to whom I am referred and to the insurance company or other entity responsible for payment for all or portion of my care.
- I authorize Dr. Lazarus, D.C./Dr. Murphy, D.C. and their staff to perform any services needed during diagnosis and treatment and I authorize payment of insurance benefits to Lazarus Chiropractic, Inc. for services rendered.
- Our policy requires payment for services rendered at the time of visit unless other arrangements have been made with the office manager. I agree to pay 1% interest per month on any overdue balances. I understand that I am ultimately liable for all charges for services rendered.
- Please note that we reserve the right to charge for appointments missed or cancelled without 24 hours advance notice.

_____
PRINT NAME

_____ _____
PATIENT (OR AUTHORIZED PERSON) SIGNATURE DATE