New Patient Packet

Loomis LifeCare · 6205 S. Walnut St., Loomis, CA 95650 · (916) 652-7373

Welcome

Thank you for choosing Loomis LifeCare. Please take about 20 minutes to complete this packet before your first visit.

Check all boxes that apply. If a question does not apply to you, leave it blank. Sections 1–6 are about you and your health; Section 7 needs your signature.

1. Patient Information

ABOUT YOU

Last name _____ **First name** _____ **M.I.** _____

Today's date _____ **Birthdate** _____ **Age** _____

Height _____ **Weight** _____

Sex: ☐ Male ☐ Female **Status:** ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

CONTACT

Address _____

City _____ **State** _____ **Zip** _____

Cell phone _____ **Home / work phone** _____

Email _____

WORK & FAMILY

Employer or school _____ **Occupation** _____

Spouse's name _____ **Spouse's employer / occupation** _____

EMERGENCY CONTACT

Name _____ **Relationship** _____ **Phone** _____

HOW YOU FOUND US

Who may we thank for referring you? _____

How did you hear about us? _____

2. Your Current Concern

What brings you in today? _____

Main concern #1: _____ **Main concern #2:** _____

How intense are your symptoms right now? (circle) 0 = no symptoms · 10 = intense symptoms

0 1 2 3 4 5 6 7 8 9 10

Where do you feel pain or other symptoms? (check all that apply)

☐ Head ☐ Jaw/TMJ ☐ Neck ☐ Shoulder (L / R) ☐ Upper back ☐ Mid back ☐ Low back ☐ Hip (L / R) ☐ Arm/Elbow (L / R) ☐ Wrist/Hand (L / R) ☐ Leg/Knee (L / R) ☐ Ankle/Foot (L / R) ☐ Other: _____

What does it feel like? (check all that apply)

☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull ☐ Aching ☐ Cramping ☐ Nagging ☐ Sharp ☐ Shooting ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Swelling ☐ Other: _____

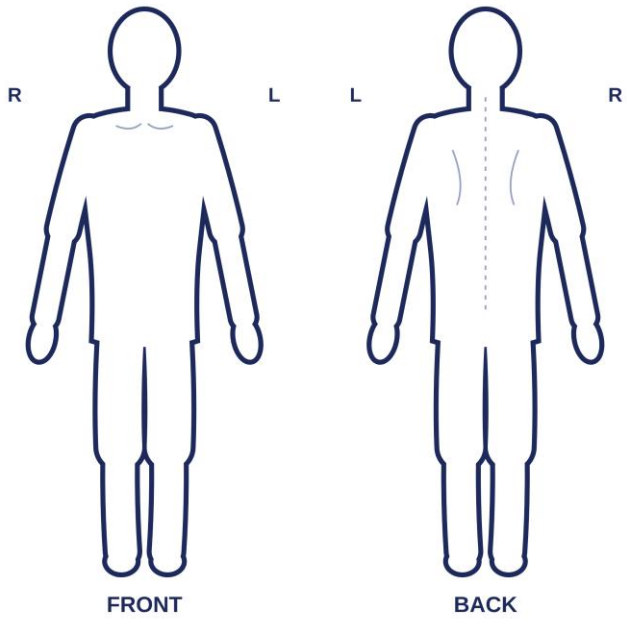
When did it start, and how? _____

What makes it worse? _____ **What makes it better?** _____

Pain Diagram

Using the symbols below, mark the areas on the body where you feel each sensation. Include all affected areas, and draw an arrow to show any pain that travels or spreads.

Aching	Burning	Numbness	Pins & needles	Stabbing
A A A	**X X X**	**= = =**	**o o o**	**/ / /**



3. How It Affects Your Life

How much is your condition interfering with each area? (check one per row)

Area	No effect	Mild	Moderate	Severe
Work / productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Exercise / sports	☐	☐	☐	☐
Recreation / hobbies	☐	☐	☐	☐
Family / relationships	☐	☐	☐	☐
Socializing	☐	☐	☐	☐
Self-care / home tasks	☐	☐	☐	☐
Energy	☐	☐	☐	☐
Mood / attitude / patience	☐	☐	☐	☐
Creativity / focus	☐	☐	☐	☐

Because of this condition, do you feel: ☐ In pain ☐ Sad ☐ Angry ☐ Frustrated ☐ Scared ☐ Less happy

How have others been affected? ☐ No one is affected ☐ They haven't noticed a problem ☐ They tell me to do something ☐ People avoid me

What are you afraid this is affecting, or will affect? ☐ Job ☐ Kids ☐ Marriage ☐ Future ability ☐ Self-esteem ☐ Sleep ☐ Time ☐ Finances ☐ Freedom

Are you afraid it might turn into another condition? ☐ Arthritis ☐ Need for surgery ☐ Chronic fatigue ☐ Fibromyalgia ☐ Depression ☐ Heart disease ☐ Diabetes ☐ Cancer ☐ A family health problem

Give examples of how it has affected your job, relationships, finances, family or activities:

_____

What has it cost you? (time, money, happiness, freedom, sleep, promotion, etc.)

1. _____

2. _____

What concerns you most about this problem? _____

Where do you picture yourself in 1–3 years if this is not taken care of? _____

4. Health History

How have you taken care of your health in the past? ☐ Medications ☐ Routine medical ☐ Emergency room ☐ Exercise ☐ Nutrition/diet ☐ Vitamins ☐ Holistic care ☐ Chiropractic ☐ Other: _____

How did it work out? ☐ Great results ☐ Some results ☐ Bad results ☐ Nothing changed ☐ Didn't get worse ☐ Didn't last long ☐ Still trying ☐ Confused

Past injuries and trauma (describe and give the year)

Type	Details and year
Car accidents	
Work injuries	
Sports injuries	
Falls, surgeries or other	

Conditions you have now or have had (check all that apply)

☐ AIDS/HIV	☐ Depression	☐ Hepatitis	☐ Osteoporosis
☐ Alcoholism	☐ Elbow / wrist / hand issues	☐ Hip issues	☐ Reproductive issues
☐ Anxiety	☐ Foot / ankle issues	☐ Immune issues	☐ Ringing in ears
☐ Arteriosclerosis	☐ GERD / acid reflux	☐ Lymphatic issues	☐ Scoliosis
☐ Arthritis	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Back pain	☐ Heart / cardiovascular disease	☐ Neck pain	☐ TMJ issues
☐ Cancer	☐ Circulation issues	☐ Childhood illness	☐ Urinary issues
			☐ Other: _____

Gut, hormone, thyroid, autoimmune, skin, respiratory and developmental conditions are covered in Section 5.

Children and pregnancy

Number of children: _____ Ages: _____ Children's health concerns: _____

Are you currently pregnant? ☐ No ☐ Yes, due date: _____ Number of past pregnancies: _____

Pregnancy-related injuries or health concerns: _____

Allergies, medications and supplements

Allergies	Medications	Supplements

5. Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____

6. Your Health Goals

The Illness–Wellness Continuum

0	1–3	4–6	7–9	10
Disease	**Poor health**	**Neutral ("comfort zone")**	**Good health**	**Optimal health**
Multiple medications, body has limited function	Symptoms, drug therapy, surgery, losing normal function	No symptoms, inconsistent nutrition and exercise, health not a priority	Regular exercise, good nutrition, wellness education	Full function, active participation, wellness lifestyle

What number represents your health today? _____ Which direction is it headed? ☐ Toward illness ☐ Staying the same ☐ Toward wellness

What are your goals?

Goal	Your answer
Immediate (symptoms to relieve)	
Short term (things you have to do)	
Long term (things you want to do)	

What would be different or better without this problem?

_____

What do you most want to get from working with us?

_____

What would that mean to you? _____

How committed are you to correcting this issue? (circle) 0 = not committed · 10 = very committed

0 1 2 3 4 5 6 7 8 9 10

Bournemouth Questionnaire — Neck Pain

Complete the neck page, the back page, or both, depending on where you have pain.

The following scales are designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average how would you rate your neck pain?												
No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain possible
2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?												
No interference	0	1	2	3	4	5	6	7	8	9	10	Unable to carry out activity
3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social and family activities?												
No interference	0	1	2	3	4	5	6	7	8	9	10	Unable to carry out activity
4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?												
Not at all anxious	0	1	2	3	4	5	6	7	8	9	10	Extremely anxious
5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?												
Not at all depressed	0	1	2	3	4	5	6	7	8	9	10	Extremely depressed
6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?												
Have made it no worse	0	1	2	3	4	5	6	7	8	9	10	Have made it much worse
7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?												
Completely control it	0	1	2	3	4	5	6	7	8	9	10	No control whatsoever

Office use only — Total score (0–70): _____

Bournemouth Questionnaire — Back Pain

Complete the neck page, the back page, or both, depending on where you have pain.

The following scales are designed to find out about your back pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average how would you rate your back pain?											
No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain possible
2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?											
No interference	0	1	2	3	4	5	6	7	8	9	10	Unable to carry out activity
3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social and family activities?											
No interference	0	1	2	3	4	5	6	7	8	9	10	Unable to carry out activity
4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?											
Not at all anxious	0	1	2	3	4	5	6	7	8	9	10	Extremely anxious
5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?											
Not at all depressed	0	1	2	3	4	5	6	7	8	9	10	Extremely depressed
6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?											
Have made it no worse	0	1	2	3	4	5	6	7	8	9	10	Have made it much worse
7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?											
Completely control it	0	1	2	3	4	5	6	7	8	9	10	No control whatsoever

Office use only — Total score (0–70): _____

Bournemouth Questionnaire: Bolton JE, Breen AC, J Manipulative Physiol Ther 1999 (back); Bolton JE, Humphreys BK, J Manipulative Physiol Ther 2002 (neck).

7. Consents & Acknowledgments

Patient name (print): _____ Date of birth: _____

Informed Consent to Chiropractic Treatment

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are risks associated with such treatment. In particular you should note:

1. While rare; some patients may experience short term aggravation of symptoms including soreness, muscle tightness, and ligamentous pain.
2. There are reported cases of stroke associated with common neck movements including rotation manipulation of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between the cervical spine manipulation and the occurrence of stroke. There are reported rates of occurrence showing 1 in 1 million will experience stroke. However, you are being informed of the possibility regardless of the extreme remote chance.
3. There are also reported cases of strain/sprain injuries of ligament and muscle, rib fractures in osteoporotic patients, and aggravation of low-back disc herniation. Again these injuries are very rare and the techniques employed by our doctors reduce that risk even more.
4. OPEN DOOR ADJUSTING POLICY: This office provides chiropractic care in an "open door" setting. This means that patients may be seen in the same area and may hear routine health discussions. These are considered incidental disclosures under HIPAA and are permissible under federal law. If you prefer a closed-door adjustment, you may request this at any time. Your choice will not affect the quality of care you receive.

Chiropractic treatment, including manipulation, has been the subject of government reports and multi disciplinary studies, and has been demonstrated to be a safe and effective care option for the treatment of back and neck pain as well as headaches. Other conditions involving radiating pain, numbness, muscle spasm, loss of mobility and other symptoms have also shown improvement.

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor or referring physician, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

I have read and understand this policy. All of my questions have been answered to my satisfaction.

Patient signature: _____ Date: _____

Notice of Privacy Practices

I have received a notice of privacy practices from Loomis Lifecare regarding their use and disclosure of my health and other protected information. I understand that I can contact them with any questions or concerns.

Patient signature: _____ Date: _____

Consent for X-Rays

I give the doctors at Loomis Lifecare my consent to take any and all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards of this office. I also give my consent for films of my child (children) for the same reasons, if applicable.

Patient signature: _____ Date: _____

For female patients: To my best knowledge I am not pregnant and know of no contraindications for x-rays at this time.

Patient signature: _____ Date: _____

Legal Representative (if applicable)

Signature of legal representative: _____ Relationship to patient: _____

Office Use Only — Doctor's Consultation Notes

The patient answers above cover life effects, goals and trauma history; use this page for the clinical detail of each complaint.

	Chief complaint #1	Chief complaint #2
Complaint		
Onset		
Provocative		
Palliative		
Quality		
Time		
Stress		
Referred		
Associated		

Notes: _____

Source: _____ Doctor: _____ Date: _____