



UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY) _____

Your Last Name _____

Your First Name _____

Your Middle Name (or Initial) _____

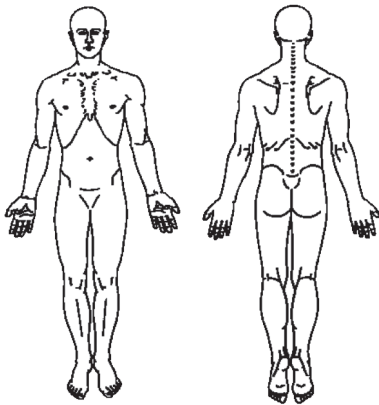
I have new contact information

Please select one:

- Progress evaluation** – I've been under active care and this is a periodic reevaluation.
- New condition** – I've been under care and a new or returning condition has emerged.
- Maintenance patient** – I'm under maintenance care with a new or returning health issue.
- Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Current symptoms: _____

1. Location (Where does it hurt?)
 Circle the area (s) on the illustration.



2. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

3. Intensity (How extreme are your current symptoms?)



4. Duration and Timing (When did it start and how often do you feel it?)

- Constant Come and goes.
- When did it start and how often? _____

5. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

6. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

- What tends to worsen the problem? _____
- What tends to lessen the problem? _____

7. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Other _____
- Over-the-counter drugs Acupuncture _____
- Homeopathic remedies Chiropractic _____
- Physical therapy Massage _____

8. What else should Life Wellness Center know about your current condition?

9. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Integumentary System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Endocrine System – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

This updated patient history is for:

- Current Patient
Periodic Re-evaluation
- Current Patient
Additional Complaint/
Exacerbation
- Maintenance Patient (circle one)
Exacerbation
Re-Occurrence
New Episode
- Inactive Patient (circle one)
Exacerbation
Re-Occurrence
New Episode

Consultation Notes

Doctor's Initials _____

UPDATED PATIENT HISTORY

11. Social History (Tell Life Wellness Center about your health habits and stress levels.)

Alcohol use Daily Weekly How much? _____
 Coffee use Daily Weekly How much? _____
 Tobacco use Daily Weekly How much? _____
 Exercising Daily Weekly How much? _____
 Pain relievers Daily Weekly How much? _____
 Soft drinks Daily Weekly How much? _____
 Water intake Daily Weekly How much? _____
 Hobbies: _____

Prayer or meditation? Yes No
 Job pressure/stress? Yes No
 Financial peace? Yes No
 Vaccinated? Yes No
 Mercury fillings? Yes No
 Recreational drugs? Yes No

Patient name _____

12. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. Is there anything else Life Wellness Center should know about your current condition, your progress or ways your current condition is affecting your life?

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Consultation Notes

Doctor's Initials _____

Life Wellness Center, Inc.
 Dr. Thomas M Schmidt
 Dr. Shannon J Score
 Dr. Ridge M Pidde
 Dr. Josiah L Thunshelle

Signature _____

Date (MM/DD/YYYY) _____



Life Wellness Center, Inc.
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 Dr. Shannon J Score
 Dr. Ridge M Pidde
 Dr. Josiah L Thunshelle
 10551 165th St. West
 Lakeville, MN 55044
 (952) 435-5300
 www.lifewellnesscenter.net

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY)

Gender

Male Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status

Single Married Divorced

Widowed Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Occupation

Child's Name and Age

Employer

May we contact you at work?

Yes No

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Who carries this policy?

Self Spouse Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

I certify that any changes to my personal information have been updated above for your records.

Signature

UPDATED CONTACT INFORMATION