

CONFIDENTIAL PATIENT HEALTH RECORD

PERSONAL HISTORY

Date: _____

Name: _____

Birth Date: _____

Address: _____

Sex: Male Female

City: _____ State: _____ Zip: _____

Home Phone: _____

Social Security #: _____

Cell Phone: _____

Driver's License#: _____

E-mail Address: _____

Business Employer: _____

Fax #: _____

Occupation: _____

Business Phone: _____

Name of Spouse: _____

Spouse's Employer: _____

Type of Work: _____

Name & Age of Children: _____

Referred to Office by: _____

Relationship: _____

Name & Number of Emergency Contact: _____

Who is responsible for your bill? You and Spouse Worker's Comp Auto Ins Medicare Medicaid

Personal Health Insurance Carrier: _____

Health Card ID#: _____

Insured Person's Name: _____

Group #: _____

Insured Person's Date of Birth: _____

Have you had previous chiropractic care? Yes No

Insured Person's Social Security #: _____

Name of Previous Chiropractor: _____

Amount of time under chiropractic care: _____

CURRENT HEALTH CONDITION

Chief Complain (why you are here today) _____

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT



When did this condition begin? _____

Has it ever occurred before? Yes No

Is condition: Auto related Work related

Other No Injury

Explain: _____

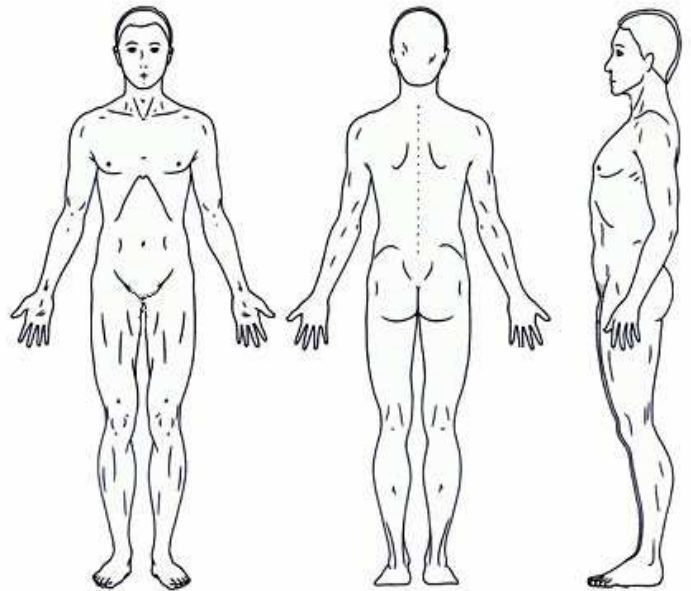
Date of Accident: _____

Time of Accident: _____

Complaint / Pain onset Date: _____

If work, have you filed and injury report with your employer?

Yes No Claim # _____



Please mark X for present conditions, O for past conditions

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Numb/Tingle Pain arms,
hands, fingers | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Pain w/Cough/Sneeze |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Foot Trouble |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Numb/Tingle Pain legs,
feet, toes | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Difficulty bending or with
Household duties | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Cancer | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Difficulty standing,
Walking, or Sitting | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Jaw Pain, TMJ, R L | <input type="checkbox"/> Menstrual Problem |
| <input type="checkbox"/> Difficulty exercising | <input type="checkbox"/> Depression | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Impotence/Sexual
Dysfunction | <input type="checkbox"/> Irritable | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Auto Accidents | <input type="checkbox"/> Tremors | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Other Accidents | <input type="checkbox"/> Allergies | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diarrhea/ Constipation |
| | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Menopausal Problems |
| | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> AIDS/HIV |
| | <input type="checkbox"/> Hepatitis (A, B, C.) | <input type="checkbox"/> ADD/ADH | <input type="checkbox"/> Skin Problems |
| | <input type="checkbox"/> PMS | | <input type="checkbox"/> Pregnant (Now) |

CIRCLE ALL THAT APPLY TO YOUR CHIEF COMPLAINT (Please list your chief complaint) _____

Location:	Onset:	What Makes It Worse?	Type of Pain:	Pain Radiating? Into:	Severity of Pain 1-10 (10 Worst)	Time Out of A Week
Left	Today	Everything	Aching	Left Head		10%
Right	This Week	Nothing	Burning	Right Shoulder	1	20%
Both	This Month	Lifting	Deep	Front Arm	2	30%
Front	This Year	Working	Dull	Back Hand	3	40%
Back		Sitting	Numbing	Ribs	4	50%
		Bending	Sharp	Buttocks	5	60%
		Standing	Soreness	Hip	6	70%
		Sneezing	Stabbing	Leg	7	80%
		Coughing	Stiffness	Foot	8	90%
			Tenderness		9	100%
		Tingling		10		

ADDITIONAL PATIENT HISTORY OF SUBLUXATION

Our patients have had literally dozens of impacts that could cause subluxations. I want to discover several of yours.

1. When was your most recent auto accident? _____
 - a. Speed: _____
 - b. Front, side, or rear-end collision? _____
 - c. Was treatment received? Yes No
 - d. If yes, where? _____
2. When was your most recent stress or strain at work? _____
 - a. Was any treatment needed? Yes No
 - b. When was the one before that? _____
 - c. What type of jobs have you done? _____
3. What sport or recreational activities do you do? _____
 - a. When was your most recent stress or strain during your activity? _____
 - b. Was any treatment received? Yes No
 - c. When was the one before that? _____
4. Is there any other injury to your spine, minor or major, that the doctor should know about? _____

VERTEBRAL SUBLUXATIONS CAN CAUSE PAIN

1. Which pain or condition have you marked the worse? _____
2. How long has it bothered you? _____
3. Vertebral Subluxations can cause irritation to different fibers within nerves. Are your pains sharp or dull?

4. Subluxations can put pressure on the spinal cord which can be constant or occasional.
Which do you feel? _____
5. Pressure on the spinal cord or nerves can be worse in the AM or PM. Which is worse for you? AM PM
6. Does the Pain radiate into an extremity or stay in one area? _____

Family History _____

On a scale of 1-10 with 10 being the highest, rate your commitment to getting rid of the problem.

1 2 3 4 5 6 7 8 9 10

Please specify any concerns that could interfere with your commitment (ex. Time, Transportation, Other):

(Please Print All Information is Confidential)

FUNCTIONAL QUESTIONNAIRE

Patient Name: _____

Date: _____

Daily Activities: Effects of Current Conditions on Performance

Care-Family Member	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Change Positions	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading/ Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Self Care- Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Self Care- Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Exercise/ Recreation	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

Patient Name: _____

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to LAKEWOODS CHIROPRACTIC of all benefits that may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to LAKEWOODS CHIROPRACTIC.

Furthermore, I hereby IRREVOCABLY ASSIGN to LAKEWOODS CHIROPRACTIC the rights and benefits under any policy of insurance, indemnity agreement, and/or charges provided by LAKEWOODS CHIROPRACTIC.

Authorization to Release Medical Record Information:

LAKEWOODS CHIROPRACTIC is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by LAKEWOODS CHIROPRACTIC. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said LAKEWOODS CHIROPRACTIC.

The undersigned certifies that He/She has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of Witness: _____ Date: _____

Signature of Patient or Responsible Party: _____ Date: _____

(Please Print, All information is confidential)

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have read and /or received a copy of

(Printed Patient Name)

LAKWOODS CHIROPRACTIC NOTICE OF PATIENT PRIVACY PRACTICES, and acknowledge my right to request a copy of the Notice in writing.

I FURTHER AGREE TO THE FOLLOWING AS EVIDENCED BY MY INITIALS. ITEMS NOT INITIALED ARE NOT AGREED TO.

_____ Telephone appointment reminders.

_____ Use of my name in testimonials

_____ To receive mailings relating to the activities at Lakewoods Chiropractic

Signature of Patient or Parent/Legal Guardian

Date

Signature of Witness

Date

(Please Print, All information is confidential)

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important for each patient to understand both objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental, and social well being, not merely the absence of disease, symptoms or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of the health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate interference to the expression of the body's innate wisdom. Our only method is the specific correction of vertebral subluxations.

POLICIES

1. All first visit charges are payable when services are rendered, since it is impossible to determine what insurance covers without a complete evaluation.
2. The fee paid for X-rays is for the analysis of those X-rays only. The film itself is the property of this office. Original X-rays can not be released.
3. I have read Lakewoods Chiropractic Notice of Patient Privacy Practices.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Lakewoods Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Lakewoods Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment.

In case of emergency, notify _____ **Phone Number** _____

I, _____, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on that basis _____ (Signature) _____ (Date)

PREGNANCY RELEASE: This is to certify that to the best of my knowledge, I am not pregnant. Lakewoods Chiropractic has my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____ Signature: _____ Date: _____

COMPLETE IF THE PATIENT IS A MINOR CHILD: Child's name: _____

I, _____ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature

Date

