Patient Information

Please complete this form. All information is strictly CONFIDENTIAL.

Patient Data

First Name ____________________ Middle Initial ______ Last Name ___________________________

Referred By _______________________________________ I prefer to be called ____________________

Mailing Address

Street Address ______________________________________ City ________________ State _________

Zip ___________________ Home # (_____)________________ Work # (_____)___________________

Cell # (_____)______________________ E-mail ____

Personal Information

Age _____ Birth Date ___/____/___ Social Security # ___________________ Number of children _____

Occupation ___________________________________ Employer ________________________________

Marital Status: S M D W Spouse's Name________________ Spouse's Occupation _______________

Emergency Contact ____ Phone # (____)______________

Primary Care Physician: ______________________________________ Phone # (____)______________

Insurance Information

Do you have health insurance? ☐ Yes ☐ No Name of company ____________________________

ID# __________________________________ Phone # (_____)______________________________________

Name of the insured ____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature ____ Date ___________________

Guardian's Signature ____ Date ___________________

Please list ALL your problem areas from MOST severe to the LEAST severe:

Symptom/Problem areas	Date first noticed	Cause of symptom (accident/ injury)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Height: ______________ Weight: _____________ ☐ Left-Handed ☐ Right-Handed

Are you happy with your current weight? ☐ Yes ☐ No What is your goal weight? ___________

For the MOST severe symptom you have listed above, please fill out below.

Have you ever had same condition? ☐ Yes ☐ No If yes, when? ____________________________

Has this condition (circle one): Gotten Worse Stayed Constant Comes and Goes

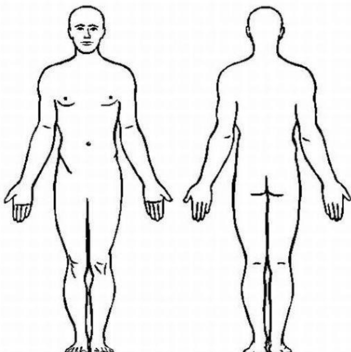
Does this condition interfere with your: ☐ Sleep ☐ Energy level ☐ Emotional Wellbeing

Have you seen a Medical Doctor for this condition? ☐ Yes ☐ No

Have you seen a Chiropractor before? ☐ Yes ☐ No If yes, when? __________________________

For what condition(s)? ____

Please mark symptoms you have on the diagram below and answer the following questions.



	YES	NO
Do you ever experience pain everyday?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in the weather affect your symptoms?	☐	☐

Circle which of these 4 categories is impacted MOST by your primary symptoms?

Work Recreational Activity Household Chores Relationships

Work

What is your primary function at work?

____

What are your primary activities at work?

☐ Sitting ☐ Standing ☐ Lifting ☐ Walking ☐ Carrying heavy equipment ☐ Typing

Other ____

Has this pain caused you to miss any work or leave work early? ☐ Yes ☐ No
If yes, how many days? ________ when?____

Has this pain lowered your productivity at work? ☐ Yes ☐ No
If yes, explain how? ____

Has this pain affected your ability to work overtime? ☐ Yes ☐ No
If yes, explain____

Recreational activities

What recreational activities (hobbies/sports) are you involved in?

____

____

Has this pain kept you from participating in any of the above activities? ☐ Yes ☐ No
If yes, explain____

What is your favorite activity?

____

Has your pain affected your ability to perform this activity? ☐ Yes ☐ No
If Yes, explain____

Has anyone commented on your performance since suffering with this pain? ☐ Yes ☐ No
If Yes, explain____

____

Household Chores

What are your main household chores?

____

Has this pain affected household chores (vacuuming, laundry, mowing lawn)? ☐ Yes ☐ No
If Yes, explain____

Have you had to get help from family members or hire someone to assist with chores? ☐Yes ☐No
If Yes, explain____

Relationships

What activities are you involved in with your family; (spouse/children)
(going to movies, taking hikes, etc.)?

____

Has this pain stopped you from doing the above activities? ☐ Yes ☐ No

Have your spouse/child/friends noticed you have been in pain? ☐ Yes ☐ No
If yes, Please explain____

Has this pain stopped you from going to dinners, movies concerts, etc.? ☐ Yes ☐ No
If yes, explain____

Has this pain stopped you from playing with your children? ☐ Yes ☐ No ☐ N/A

Helping them with their activities (i.e. homework)? ☐ Yes ☐ No ☐ N/A
If yes, explain____

Are you sensitive to fragrances or perfumes? ☐ Yes ☐ No

How would you describe your current energy level? ☐ High ☐ Medium ☐ Low

How would you describe your current stress level? ☐ High ☐ Medium ☐ Low

How would you describe your current sleep habits?

☐ Well rested sleep ☐ Adequate Sleep ☐ Restless Sleep ☐ Insomnia

Is there any additional information you would like the doctor to know?

____
____
____
____

General Symptoms

Please place a check mark in the column(s) below if you *currently* or in the *past* have had any of the following symptoms.

Symptoms	Current	Prior	Symptoms	Current	Prior
Neck pain			Tension headaches		
Neck stiffness			Migraine headaches		
Difficulty turning head			Nausea		
Pain with turning head			Vomiting		
Ache/ numbness/ tingling down arm(s)			Visual disturbances		
Pins/ needles/ tingling in finger(s)			Dizziness		
Weakness into either hand			Jaw pain/ cracking		
Dropping things out of either hand			Sinus congestion		
Neck pain affects hearing			Shoulder pain (L / R)		
Neck pain affects vision			Elbow pain (L / R)		
Neck pain affects balance			Wrist pain (L / R)		
Ringing in the ears			Leg pain (L / R)		
Upper back pain			Hip pain (L / R)		
Mid back pain			Knee pain (L / R)		
Mid back stiffness			Foot pain (L / R)		
Pain with breathing/coughing/sneezing			Fever		
Pain wrapping around to front			Cold sweats		
Rib pain			Feet cold		
Rib fracture			Hands cold		
Lower back pain			Loss of memory		
Lower back stiffness			Irritability		
Ache/ numbness/ tingling down leg(s)			Fatigue		
Numbness in toes			Diarrhea		
Sexual dysfunction			Depression		
Bowel dysfunction			Sensitive to light		
Bladder dysfunction			Head feels heavy		
Do you wear orthotics			Shingles		

Medical History

Is there a chance that you are pregnant? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No (Please list by name and for what condition.)

____

____

Are you currently taking any vitamins/ supplements? ☐ Yes ☐ No

What vitamins, minerals, or herbs do you currently take? (Please list by name and for what condition.)

____

____

Have you ever:	Yes	No	Briefly Explain
Broken bones?	☐	☐	______________
Been hospitalized?	☐	☐	______________
Been in an auto accident?	☐	☐	______________
Had sprains/strains?	☐	☐	______________
Been struck unconscious?	☐	☐	______________
Had surgery?	☐	☐	______________

Family History

Present and past health conditions (example: heart disease, cancer, diabetes, arthritis, etc.)

Family Member	Conditions

Thank you for filling out the forms.
The information you have provided will better assist us with your care in this office.
We look forward to serving you.

INFORMED CONSENT TO CHIROPRACTIC CARE

TERMS OF ACCEPTANCE FOR 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 that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives. Please be aware the clinic is under video and audio surveillance for training and security purposes.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation is a disturbance to the nervous system that occurs when one or more of the 24 vertebrae in the spinal column becomes misaligned and/ or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/ or reduced by an adjustment.

Adjustment is the specific application of forces to correct and/ or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as extremity adjustment, physiotherapy and/ or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

______________________________	______________________________
Print Name	**Signature**

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, ____________________________ being the parent or legal guardian of ___________________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/ her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____________________

	FINANCIAL PAYMENT POLICY

INSURANCE

Insurance coverage is never guaranteed. Any benefits quoted by our staff are not a guarantee of benefits. Your signature below assigns assignment to this office for collection of benefits and also authorizes this office to use and disclose protected health information for purposes of treatment, payment, and healthcare operations. You have a right to review our posted privacy policy before you sign this consent and you may void your consent at anytime by contacting us.

FINANCIAL POLICY

The office manager may approve account balances. Active monthly payments are required. Monthly payments are due on the 10th of each month. If account becomes 60 days past due, agreement is null and void and payment must be made at the time of service. Past due accounts may be sent to a third party collection agency.

We do offer a *time of service* discount when services are paid in full at time of the visit. This discounted amount will be passed on to your insurance company contract permitting. Please feel free to ask us any financial question you may have. Our intent is to provide you with the highest level of service as well as care.

All questions regarding financial matters have been answered to my complete satisfaction. I have read and fully understand the above financial payment policy.

____________________________________ ____________________

Signature Date

	CONSENT to **LEAVING MESSAGES** **CONSENT** to **SHARING INFORMATION** with **Family/ Friends**

CONSENT to LEAVING MESSAGES

I understand that my healthcare information at Lifeplus Health Centers, P.S. is protected and I have received a copy of its Notice of Privacy Practices.

I further understand that, in order for Lifeplus Health Centers to leave **detailed messages containing specific medical information** on my voice mail or answering machine, I need to give permission to Lifeplus Health Centers.

Consent for Leaving Messages
I consent to information regarding my or my child's (under the age of 18) detailed appointment reminders, insurance benefit information, and/ or instructions be left on my voice mail or answering machine.
[ ] YES [ ] NO

CONSENT for SHARED INFORMATION with Family & Friends

The name(s) listed below are family members or friends to whom I grant permission for my health care providers and their representatives at Lifeplus Health Centers to verbally discuss my care using their best judgment, and grant them permission to disclose health information that is relevant to my care or relevant for payment. **[ ] YES [ ] NO**

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of information form.

NAME	RELATIONSHIP
1.______________________________	______________________________
2.______________________________	______________________________
3.______________________________	______________________________

______________________________ ______________________________
Patient/ Parent Signature Date

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.
This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to my provider at Lifeplus Health Centers.