LOVING HANDS CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION AND HISTORY

Chart #_____

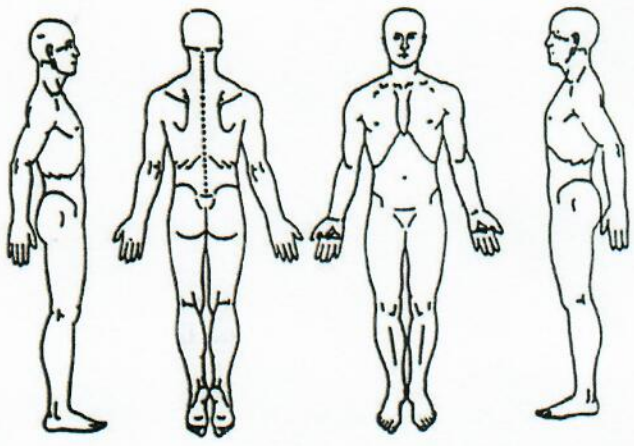
Name:_____ Date of Birth:_____ Age:_____ Date:_____
Address:_____ Gender:_____
City:_____ State:_____ Zip:_____ Home Phone:_____
Email Address: _____ Cell Phone:_____
Best way to contact you (check all that apply): ☐Email ☐Cell ☐Home ☐Work Work Phone:_____
Occupation:_____ Employer:_____
Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Domestic Partner #of Children:_____
Please provide your *insurance card* so we can make a copy Name of spouse/partner:_____
In Case of Emergency; Contact Name:_____ Relationship:_____
Cell Phone:_____ Home/Work Phone:_____
Are you working with an attorney? ☐No ☐Yes Attorney's Name:_____ Date of Injury:_____
How did you hear about our office?_____

PATIENT'S CONDITION

What are your major symptoms/problems?_____
When/how did your problem begin?_____
Have you had this problem before (when)?_____
What makes the problem worse?_____
What makes the problem better?_____
Is your problem getting better or worse, and how so?_____
Does the pain: radiate or travel in your body? Where? _____
Are you experiencing any numbness, tingling or spasms? Where? _____
Describe how it feels?_____
What have you tried to help your condition? ☐Chiropractic ☐Orthopedic ☐Neurologist ☐Physical Therapy ☐Surgery ☐Massage ☐Acupuncture ☐Naturopathic ☐Prescription Meds ☐Over-The-Counter Meds ☐Supplements ☐Heat ☐Ice
How often is your problem occurring? ☐Intermittently (25-0%) ☐Occasionally(50-26%) ☐Frequently(75-51%) ☐Constantly(100-76%)
How much do your symptoms affect your daily activities? ☐Not at all ☐A little ☐Moderately ☐Often ☐Extremely
Does your problem interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Walking ☐Sitting
What is you overall level of exercise? ☐Strenuous ☐Moderate ☐Light ☐None
How would you rate your overall health? ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor
Is there anything else we should know about your condition? _____

Circle the severity of your pain *currently*: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worse pain)
Circle the severity of your pain at its *worst*: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worse pain)

In the diagram to the right, please mark all areas that are painful



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PATIENT'S HISTORY

Please mark any conditions you are *currently*, or in the *past*, suffering from:

- ☐ Headaches/Migraines
- ☐ TMJ/Jaw Pain
- ☐ Neck Pain
- ☐ Upper/Mid Back Pain
- ☐ Lower back Pain
- ☐ Herniated/Bulging Disk
- ☐ Hip Pain
- ☐ Leg/Knee/Ankle Pain
- ☐ Shoulder Pain
- ☐ Arm/Elbow/Wrist Pain
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorders
- ☐ Cancer/Tumor
- ☐ Chronic Fatigue
- ☐ Dermatitis/Eczema
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Dizziness/Vertigo
- ☐ Drug/Alcohol Dependence
- ☐ Elevated Cholesterol
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disorders
- ☐ Liver/Gall Bladder Disorder
- ☐ Loss of Bowel/Bladder Control
- ☐ Muscular Incoordination
- ☐ Prostrate Problems
- ☐ Osteoporosis
- ☐ Season Allergies
- ☐ Smoking/Tobacco Use
- ☐ Seizure
- ☐ Sinus Infections
- ☐ Stroke
- ☐ Unexplained Weight Loss
- ☐ Visual Disturbances

Other:_____

_____

_____

Female:

- ☐ Birth Control Pills
- ☐ Irregular Cycle
- ☐ Pregnant; Weeks:_____

Number of Pregnancies:_____

Number of Deliveries:_____

Do you currently smoke/use tobacco? ☐Yes ☐No Years smoked:_____Packs/Day:_____If *no*, prior tobacco use? ☐No ☐Yes

Do you consume alcohol? ☐Yes ☐No Drinks/Week_____

Do you use recreational drug or prescription meds you are not prescribed? ☐No ☐Yes Type:_____

Please indicate any major conditions/illnesses that your immediate family member suffers from: Were you adopted? ☐No ☐Yes

Relative	Condition & Description	Living?	If deceased, at what age, and why?
Mother		Yes/No	
Father		Yes/No	
Sibling		Yes/No	
Sibling		Yes/No	
Sibling		Yes/No	

Height:_____' _____" Weight:_____lbs. Your primary care physician:_____

Name of other doctors, and their specialty, who you currently receive care from:_____

_____

Previous chiropractic care: ☐No ☐Yes; Chiropractor:_____Date:_____

Drug/food allergies or sensitivities:_____

List any medication and supplements/vitamins you are currently taking:_____

_____

Surgeries/Hospitalizations:_____

_____

Traumatic Injuries (broken bones, sprains/strains, concussions, motor vehicle accidents, etc):_____

_____

AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize the office of Loving Hands Chiropractic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

Signature_____ Date_____ Parent (if patient is a minor)_____

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Informed Consent For Chiropractic Treatment

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, instrument assisted soft tissue mobilization, stretches and exercises, electric muscle stimulation, therapeutic ultrasound, or cryotherapy spray may also be used.

The material risks inherent in chiropractic treatment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Complications could include but are not limited to: fractures, disc injuries, dislocations, muscle strain, ligament sprain, myelopathy, costovertebral strains and separations, burns, and/or skin irritations. Some patients may notice stiffness or soreness following the first few days of treatment.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as rare. The Doctor will make every reasonable effort during the taking of your history, physical examination, X-rays, and ongoing throughout treatment to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor. The likelihood of suffering a stroke following an appointment with a chiropractor is no greater than that following an appointment with a primary care physician.

Other treatment options which could be considered may include the following:

- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and analgesics.
- Self-administered over-the-counter analgesics and rest.
- Hospitalization or Surgery.

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you should discuss these with your primary medical physician.

Risks of remaining untreated: Remaining untreated may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult and less effective.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read, or have had read to me, the explanation above of chiropractic adjustment and related treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Patient's Name: _____ **Signature:** _____ **Date:** _____

Parent/Guardian: _____ **Signature:** _____ **Date:** _____

Doctor's Name: _____ **Signature:** _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- < Conduct, plan and direct my treatment and follow-up among the multiple, healthcare providers who may be involved in the treatment directly and indirectly
- < Obtain payment from third-party payers
- < Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Signature:_____ Date:_____

Printed Name (or Guardian): _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: Initials: Reason:

_____