

Patient Name: _____ Date: _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Would you like text message or email reminder? Yes No Cell Phone Provider: _____

Email Address: _____ Occupation _____ Employer _____

Date of Birth ____/____/____ Age ____ Sex: M F Marital Status: M S D W

Social Security # _____

In case of Emergency call: _____ Relationship to Patient: _____ Phone: _____

Insurance company _____ Secondary _____

Primary Physician: _____ Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. Reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

3. Past Health History:

A. Please indicate if you have a history of any of the following:

- Anticoagulant use Heart problems/high blood pressure/chest pain Bleeding problems
- Lung problems/shortness of breath Cancer Diabetes Psychiatric disorders
- Bipolar disorder Major depression Schizophrenia Stroke/TIA's Other _____
- None of the above

B. Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies: _____

D. Medications:

Medication _____

Reason for taking _____

Patient Name: _____ Date: _____

E. Surgeries:

Date

Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery

Outcome

Is there any chance that you could you be pregnant? _____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases
- Adopted/Unknown Cardiac disease below age 40 Psychiatric disease Diabetes
- Other _____ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death

Age at death

Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities/ Hobbies: _____

D. Lifestyle circle: *Exercise:* ___ days/week *Alcohol:* ___/week *Tobacco:* ___ packs/day/week *Drug use:* Y/N *Poor Diet:* Y/N

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

- Asthma/difficulty breathing COPD Emphysema Other _____ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

- Heart surgeries Congestive heart failure Murmurs or valvular disease Heart attacks/MIs Heart disease/problems Hypertension Pacemaker Angina/chest pain Irregular heartbeat Other _____ None of the above

Have you had any of the following **neurological (nerve-related)** issues?

Patient Name: _____ **Date:** _____

- Visual changes/loss of vision One-sided weakness of face or body History of seizures One-sided decreased feeling in the face or body Headaches Memory loss Tremors Vertigo Loss of sense of smell
 Strokes/TIAs Other _____ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

- Thyroid disease Hormone replacement therapy Injectable steroid replacements Diabetes
 Other _____ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones Hematuria (blood in the urine) Incontinence (can't control) Bladder infections
 Difficulty urinating Kidney disease Dialysis Other _____ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea Difficulty swallowing Ulcerative disease Frequent abdominal pain Hiatal hernia Constipation
 Pancreatic disease Irritable bowel/colitis Hepatitis or liver disease Bloody or black tarry stools
 Vomiting blood Bowel incontinence Gastroesophageal reflux/heartburn Other _____ None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Aleve) HIV positive
 Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia
 Hypercoagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy Regular aspirin use
 Other _____ None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns Significant rashes Skin grafts Psoriatic disorders Other _____ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

- Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture Spinal surgery Joint surgery
 Arthritis (unknown type) Scoliosis Metal implants Other _____ None of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder Homicidal ideations Schizophrenia
 Psychiatric hospitalizations Other _____ None of the above

For females only: Are you or is there a chance that you are pregnant? _____ if yes, how far along _____

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. I certify that I, and/or my dependent(s), assign directly Lodes Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named facility may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient or Guardian/Personal Representative Signature _____
 Date _____

Patient Name: _____

Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities and employee review activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law; we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.506.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT. AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative

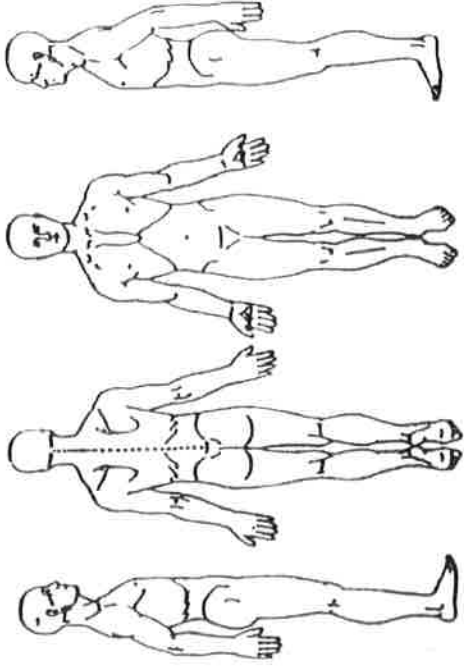
Date

Printed Name

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Indicate all areas of complaint on the diagram provided:



Please describe symptoms below:
Start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
- If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?
○ Did the symptom begin suddenly or gradually? (circle one) _____
○ How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
○ Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- What makes the symptom better? (circle all that apply):
○ Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
○ Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
○ If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
○ Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?
○ Did the symptom begin suddenly or gradually? (circle one) _____
○ How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
○ Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
○ Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
○ Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no

Patient Name: _____ Date: _____

- If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one) _____
 ○ Morning Afternoon Evening Night Unaffected by time of day

Welcome to our wellness center,

We are here to discover your goals and priorities as it relates to your health and wellness. Your answers will help us determine how we can best help you.

On a scale of 1 – 10, rate the importance for you to achieve the following:

1 = not important 10 = necessary

- Lose weight 1 2 3 4 5 6 7 8 9 10
- Get fit 1 2 3 4 5 6 7 8 9 10
- Eat better 1 2 3 4 5 6 7 8 9 10
- Reduce stress 1 2 3 4 5 6 7 8 9 10
- Stop smoking 1 2 3 4 5 6 7 8 9 10
- Reduce pain 1 2 3 4 5 6 7 8 9 10
- Increase my mobility 1 2 3 4 5 6 7 8 9 10
- Improve my posture 1 2 3 4 5 6 7 8 9 10
- Improve my sleep 1 2 3 4 5 6 7 8 9 10
- Learn about wellness 1 2 3 4 5 6 7 8 9 10
- Learn about wellness products that are right for me 1 2 3 4 5 6 7 8 9 10
- Other _____ 1 2 3 4 5 6 7 8 9 10

Which of the above would you say is the most important goal for you to achieve and why?

Have you ever attempted to accomplish this goal in the past? Yes No
If yes, what happened and what prevented you from maintaining your results?

Do you have any questions or comments?

Remember: your health is your greatest asset, the more of it you have the healthier you are. We are looking forward to meeting you soon!

Patient Name: _____ Date: _____

Sincerely,
Dr. Michael Lodes and Dr. Brett Wharton