Adult Patient Introduction

Name: _____ Date of Birth ____/____/____

Address: _____ Male / Female

_____

Home: _____ Marital Status:

Cell: _____ Married Single

Work: _____ Divorced Widowed

Email: _____ Partner

Spouse's Name: _____

Children's Name/Age: _____

_____

Insurance Information (if applicable)

Name of insured _____

Date of Birth _____

Insurance Company _____

Phone # _____

Group ID # _____

Policy# _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Lighthouse Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to Lighthouse Chiropractic will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that if I suspend or terminate my case and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Name Patient Signature Date

Guardian's Name Guardian's Signature Date

I. General Information

How did you hear of our office?

Business Card Web Search Doctor Friend Fitness Center Event

Who may we thank for referring you? _____

Have you ever been to a Chiropractor before? Yes No

Date of Last visit: _____ Reason for Care: _____

How long were you under care: _____ Were x-rays taken? Yes No

II. Chief Complaint

Reason for seeking Chiropractic Care today: _____

Is issue a result of: Car Accident Work Related Other _____

Have you seen any other doctor for this problem? Yes No Dr. Name _____

List any medications: _____

_____

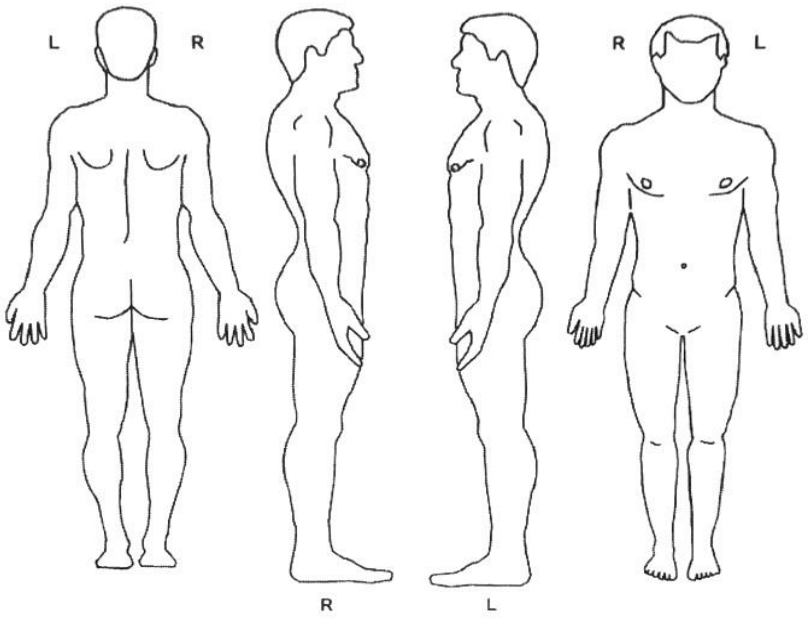
Are you Left Handed / Right Handed

What type of work do you do? _____

How many hours do you spend:

Sitting _____ Standing _____ Driving _____ in Manual Labor _____

Circle the areas where you have any problems
Please also describe these problems.



Mark as follows:
A - Ache B - Burning N - Numbness P - Pins & Needles
S - Stabbing O - Other - Describe _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you Pregnant? _____ Weeks Due Date _____

Have you had any Concussions? Yes / No How many? _____ When? _____

Have you had any Surgeries Yes / No

Please Explain _____

_____

_____

_____

Have you had or have the following?

Symptoms and Problems	Constant or Frequent	Occasional
Pain:	____	____
Neck	____	____
Shoulder(s): Right Left Both	____	____
Arm/Hand: Right Left Both	____	____
Mid Back	____	____
Low Back	____	____
Hip/Sciatic: Right Left Both	____	____
Leg/foot: Right Left Both	____	____
Joints	____	____
Headaches or Migraines	____	____
Chest Pain	____	____
Disc Problems	____	____
Joint Swelling	____	____
Muscle Spasms	____	____
Numbness/Tingling	____	____
Dizziness/Vertigo	____	____
Ringing in Ears	____	____
Cough	____	____
Flu/Fever	____	____
Male Problems	____	____
Female Problems	____	____
Weakness	____	____
Fatigue	____	____
Heartburn/Ulcers	____	____
Constipation	____	____
Diarrhea	____	____

Conditions	Check all that apply
Arthritis	____
Bursitis	____
Tendonitis	____
Osteoporosis	____
Insomnia	____
Anxiety	____
Depression	____
Blood Disorders	____
High/Low Blood Pressure	____
Varicose Veins	____
Heart Problems	____
Diabetes	____
Kidney Problems	____
Lupus	____
Epilepsy	____
Cancer	____
Hearing Loss	____
Frequent Colds	____
Asthma	____
Allergies	____
Skin Conditions	____

III. Childhood History (Prior to age 18)

Research is showing that many of the health challenges that occur later in life have their origins during our developmental years, some starting at birth. Please answer these questions to the best of your ability.

	Yes	No	Details
Did you have any childhood illnesses? (chicken pox, measles, etc.)	____	____	_____
Did you have any serious falls as child? (tree, seesaw, crib, etc.)	____	____	_____
Did you play youth sports?			
Did you have any surgeries?	____	____	_____
Prolonged use of medications?	____	____	_____
(antibiotics, inhalers, etc.)	____	____	_____
Any car accidents?			
Were you vaccinated?	____	____	_____
Were you under regular Chiropractic care?	____	____	_____
	____	____	_____

IV. Adult History (age 18 to present)

	Yes	No	Details
Do/did you smoke?			
Do/did you drink?	____	____	_____
Do/did you play sports?	____	____	_____
Did you have any surgeries?	____	____	_____
Any car accidents?	____	____	_____
	____	____	_____
Any work injuries?	Yes	No	Details
Prolonged use of medications?	____	____	_____
(antibiotics, inhalers, etc.)	____	____	_____
Do you:			
Drink water?			
Consume Caffeine?	____	____	_____
Consume vitamins or supplements?	____	____	_____
	____	____	_____

On a scale of 1 (being none) to 10 (being severe), rate your stress at: Home _____ Work _____

On a scale of Poor, Good, Excellent, describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

V. Wellness Commitment

At Lighthouse Chiropractic, we are dedicated to achieving the goal of total lasting health for our members. To better help you achieve this' we need to understand your commitment to being healthy. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness:

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

VI. Missed Appointment Policy

With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment. We would prefer the make up appointment to be within the same week.

In the instance of a no show, we reserve the right to charge you a $20.00 fee. Thank you for your understanding.

Patient/Guardian Name Patient/Guardian Signature Date

***Massages must be cancelled 24 hours in advance or you will be charged $50 for the missed massage. ***

VII. Consent to Initiate Care

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Our only practice objective is to eliminate subluxation which interferes with the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ , have read and fully understand the above statements.
(Please Print Name)

I hereby authorize the Doctor to provide any and all forms of evaluation, x-rays and care that may be indicated in connection with the patient above, and further authorize the consent that the Doctor chooses and employs such assistance as he sees fit. I also understand that prior to care, a full explanation of the procedure(s) involved will be given.

Patient/Guardian Name Patient/Guardian Signature Date

Notice of Privacy Practices Acknowledgement
Lighthouse Chiropractic

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

OR

_____

Signature of Personal Represent: Date

Authority of Personal Representative to Sign for Patient (check one):

___ Parent ___ Guardian ___ Power of Attorney _____ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

_____

Lighthouse Chiropractic Office Use Only

I tried to obtain written Acknowledgement by individual note above of recipt of our **Notice of Privacy Practices**, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgment

___ A communication barrier prevented us from obtaining acknowledgement

___ The individual was unwilling to sign

___ Other: _____

_____ _____

Signature of Personal Representative Date

Medical Information Release Form

(HIPPA Release Form)

_____ _____

Patient's Name (Please Print) Patient's Date of Birth

Release of Information

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____ My Insurance Company (only minimum necessary information needed for billing purposes)

_____ Spouse _____
(Name – please print)

_____ Child(ren) _____
(Name(s) – please print)

_____ Other _____
(Name/relationship – please print)

_____ My information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

_____ _____

Signature of Personal Representative Date