LAKES CHIROPRACTIC AND WELLNESS : Patient Intake Form

SECTION ONE:

Name: ____ Date: _____________ CASE # _________

Address: ____ Date of Birth: ___________

City: ______________________________________ State: __________ Zip: ___________________

Home Phone: _______-________-________ Cell Phone: _______-_______-________

Email Address: _________________________________ Occupation: _________________________

How were you referred to us: ____ GOOGLE SEARCH____ WEBSITE____ NEWSPAPER AD___ LOCATION______

___INSURANCE COMPANY ___ REFERRED BY WHOM: _____________________________________

Name of Health Insurance Company: ____

Policy #: __________________________________ Group #________________________________

Policy Holders Name: ____ DOB: ___________________

SECTION TWO:

List any **Allergies**: ____

List any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist/Hand

☐ Other: ____

List **ALL Past Medical** conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression

☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain

☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure

☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain

☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's

☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain

☐ Stroke/Heart Attack ☐ Other: ____

List all **MEDICATIONS AND THE REASON** you are currently taking:

1______________________________________ 2______________________________________

3______________________________________ 4______________________________________

5______________________________________ 6______________________________________

Are you allergic to any medications: ☐ No ☐Yes____

Do you take any nutritional supplements? If so, please list: ____

Family History:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition

☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neurological Problems ☐ Parkinson's ☐ Polio

☐ Prostate Problems ☐ Stroke/Heart Attack Other:____

SECTION THREE:

Have you had any auto or other accidents in the past? ☐ No ☐Yes Date of Accident? ________________________________

Date of last physical examination? ________________________________

Do you smoke? ☐ No ☐Yes –How many per day? ____________________ Are you a former smoker? ☐ No ☐Yes

Do you drink alcohol? ☐ No ☐Yes - how many per day/week? ________________

Do you drink caffeine? ☐ No ☐Yes - how much per day? ________________

Do you exercise? ☐ No ☐Yes (what forms and how often): ________________________________

Have you ever had Chiropractic or Medical care previously for this problem? ☐YES ☐NO

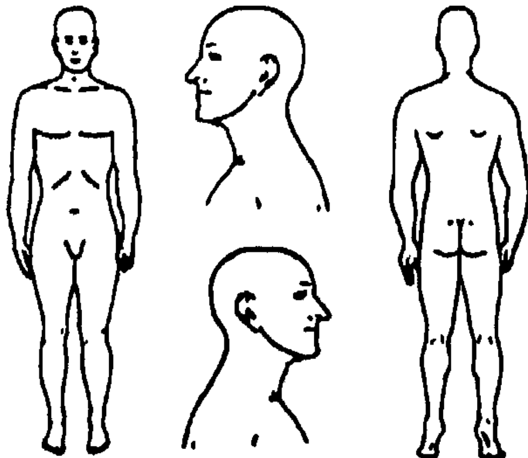
Where did you receive treatment? ________________________________

How did you respond? ________________________________ When was your last visit? ____________

What was done on your visits? ________________________________

Were X-Rays or MRI's taken? Yes____ No____ What facility has your films? ________________________________

MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



What are your expectations from us?

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity

SECTION FOUR:

What is your SINGLE WORST complaint? 1)____________________Date problem began? __________

How did this problem begin (falling, lifting, etc.)? ________________________________

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: ________________________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? ________________________________

What makes your pain better (ice, heat, massage, etc)? ________________________________

What is your **SECOND worst** complaint? 2)________________________________Date problem began? ____________

How did this problem begin (falling, lifting, etc.)? ____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly □ Frequently □ Occasionally □ Intermittently

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: ____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc.)? ____

What makes your pain better (ice, heat, massage, etc.)? ____

What is your **THIRD worst** complaint? 3) ________________________________Date problem began? ____________________

How did this problem begin (falling, lifting, etc.)? ____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly □ Frequently □ Occasionally □ Intermittently

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: ____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc.)? ____

What makes your pain better (ice, heat, massage, etc.)? ____

Are there any other complaints, concerns, or issues we need to discuss at this time?

____

____

We will submit your claim to the insurance you have provided. In the event your insurance denies the claim for no coverage, max limit, or non-covered benefit you will be responsible for all charges.

Signature____ Date _______________

LAKES CHIROPRACTIC AND WELLNESS

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

______________________________ ____________________
Patient Name (please print) Date

____
Parent, Guardian or Patient's legal representative

____
Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

LAKES CHIROPRACTIC AND WELLNESS

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to Lakes Chiropractic & Wellness , as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Lakes Chiropractic and Wellness or their attorneys in order to claim such benefits.

I also assign and/or convey Lakes Chiropractic and Wellness, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort-feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). Lakes Chiropractic and Wellness or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Lakes Chiropractic and Wellness, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

We will submit and appeal your claims to the insurance you provided. In the event your insurance continues to deny your claim.

This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature: ____ date: _________________

Name: ____

LAKES CHIROPRACTIC AND WELLNESS
DOCTOR-PATIENT RELATIONSHIP AND CHIROPRACTIC INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to improve health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent healing ability through the activation of the central nervous system. The success of your chiropractic treatment often depends on underlying physical and spinal conditions. It is important to understand what to expect from your chiropractic health care. Some conditions will heal quickly and some may take more time.

ADJUSTMENTS

The Doctors at Lakes Chiropractic and Wellness mainly use diversified manipulation techniques, which is the most widely utilized form of Chiropractic Manipulative Treatment (CMT). CMT involves highly skilled touch and inherent knowledge to be able to diagnose and treat the spine and extremities. The Doctors of Lakes Chiropractic also utilize many rehabilitative techniques. These include active and passive therapeutic exercises, as well as specialized soft-tissue techniques to decrease pain, increase range of motion, and restore proper biomechanics to the involved joints and musculature.

INFORMED CONSENT FOR CHIROPRACTIC CARE

As a patient, you give the Doctors of Lakes Chiropractic and Wellness permission and authority to care for you in accordance with their chiropractic findings. Chiropractic adjustments or other clinical procedures are typically beneficial and seldom cause problems. In rare cases, the patient may experience soreness and mild pain after a treatment. It is extremely rare, but as with any form of health care there are inherent risks which include, but are not limited to the following: fractures, sprain/strains and stroke. It is your responsibility to tell the doctor everything you know about your health conditions which would otherwise not come to the attention of the doctor of chiropractic.

The doctor may advise you to perform or discontinue certain activities that may affect your condition. The patient hereby understands it is their responsibility to monitor their own health and assume all risks related to their behavior and / or decisions to care in this office.

AUTHORIZATION

In certain cases, it may be necessary for the doctor to discuss or send reports to other doctors, attorneys and or insurance carriers. As a patient, you are giving the doctor permission to do so.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy. I understand the following and give my consent.

____ Date________________________

Printed name of patient, parent, guardian or authorized representative

____ Date________________________

Signature of patient, parent, guardian, or authorized representative