CHIROPRACTIC CENTER OF LAKELAND

New Patient Intake

Name: _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Ph**: _____**Wk Ph:** _____

Birthdate: _____**SSN:** _____ **Email:** _____

Status: Single Married Divorced Widowed **Children:** Yes No **How Many:** _____

Are you considered a minor? Yes No **If Yes, who is the responsible payer?** _____

Occupation: _____ **Employer:** _____

Family Doctor: Yes No **Name of Doctor:** _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Do you have insurance we will be using? Yes No **Insurance Company:** _____

How did you hear about our office?: _____

Rate your overall internal health: Excellent Good Fair Poor **Rate your external health:** Excellent Good Fair Poor

Past Medical History

For the conditions below, place a check in the "past" column if you have had the condition in the past.
If you presently have any condition listed below, please place a check in the present column.

Condition	Past	Present
Headaches	☐	☐
Neck Pain	☐	☐
Upper Back Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Shoulder Pain	☐	☐
Elbow/Arm Pain	☐	☐
Wrist Pain	☐	☐
Hand Pain	☐	☐
Hip Pain	☐	☐
Upper Leg Pain	☐	☐
Knee Pain	☐	☐
Ankle/Foot Pain	☐	☐
Jaw Pain	☐	☐
Joint Pain/ Stiffness	☐	☐
Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Cancer	☐	☐
Tumor	☐	☐

Condition	Past	Present
Asthma	☐	☐
Sinus Problems	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Angina	☐	☐
Kidney Stones	☐	☐
Kidney Disorders	☐	☐
Bladder Infection	☐	☐
High Cholesterol	☐	☐
Loss of Bladder Ctrl	☐	☐
Prostate Problems	☐	☐
Abnormal Wt Loss/Gain	☐	☐
Loss of Appetite	☐	☐
Abdominal Pain	☐	☐
Ulcer	☐	☐
Hepatitis	☐	☐
Liver Disorder	☐	☐
Gall Bladder Disorder	☐	☐

Condition	Past	Present
General Fatigue	☐	☐
Thyroid Disorder	☐	☐
Muscular Incoordination	☐	☐
Visual Disturbances	☐	☐
Dizziness	☐	☐
Diabetes	☐	☐
Excessive Thirst	☐	☐
Frequent Urination	☐	☐
Addiction Drug/Alcohol	☐	☐
Allergies	☐	☐
Depression	☐	☐
Systemic Lupus	☐	☐
Fibromyalgia	☐	☐
Epilepsy	☐	☐
Skin Conditions	☐	☐
HIV/AIDS	☐	☐
For Women:	☐	☐
Birth Control	☐	☐
Hormone Replacement	☐	☐

List Treatments for <u>Past</u> Conditions: _____

List ALL Medications you are <u>Currently</u> Taking: _____

_____

List any Allergies: (including food) _____

List any Surgeries: _____

Family Medical History

Please indicate if you have any immediate family members with the following conditions:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus/Fibromyalgia
☐ Heart Problems ☐ Cancer ☐ Mulitple Sclerosis

Other Family Medical history: _____

Social History

Do you smoke: Yes No **How Much:** _____ **Drink Alcohol:** Yes No **How Much:** _____

For Women Only: Pregnant? Yes No **How Long:** _____ **Nursing?:** Yes No

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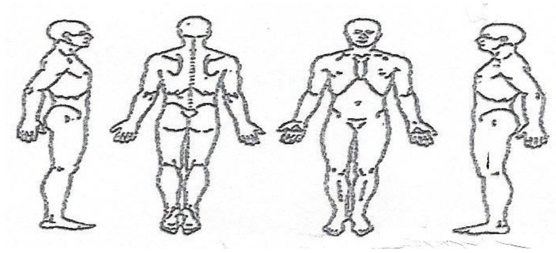
New Patient Intake

Please indicate on the drawing below where you are experiencing your symptoms



Where does it hurt: ________________________________ **When Did It Start:** ________________________
Pain Level (0= No Pain/10=Highest Pain) 0 1 2 3 4 5 6 7 8 9 10
How often does it occur: Occasionally (0-25% of the time) Intermittently (26-50% of the time) Frequently (51-75% of the time) Constantly (76-100% of the time)
Please describe your pain: Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing
What aggravates your symptoms: ____
Doctor's Notes: ____
____
____

Where does it hurt: ________________________________ **When Did It Start:** ________________________
Pain Level (0= No Pain/10=Highest Pain) 0 1 2 3 4 5 6 7 8 9 10
How often does it occur: Occasionally (0-25% of the time) Intermittently (26-50% of the time) Frequently (51-75% of the time) Constantly (76-100% of the time)
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Please describe your pain: Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing
What aggravates your symptoms: ____
Doctor's Notes: ____
____
____

Current Treatment of Symptoms
Have you seen anyone else for these symptoms: *Yes* *No* Who: ________________________
List any treatment given for these symptoms: ____
List any medications given for these symptoms: ____

Patient Signature: ____ **Date:** ____________________

Chiropractic Center of Lakeland

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Print Name

_____ _____

Sign Name **Date**

Chiropractic Center of Lakeland

Term of Acceptance

When a patient care at the Chiropractic Center of Lakeland and we accept a patient for such care, it is essential for both to be working toward a common goal.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interferes with the expression of the body's innate wisdom. It is important all patients understand both the objective and the method used to attain our goal. The following definitions will help to educate each patient.

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

Adjustment: A specific application of forces to facilitate the body's correction of the spinal Subluxation. Our method of correction is performed by mechanical device as well as by hand.

Spinal Subluxation: A misalignment of one or more of the 24 vertebrae in the Spinal Column which causes alteration and interference with the transmission of information from the brain to all systems of the body, thus having a positive effect on the body's organs and systems, even down to the cellular level.

We do not offer to diagnose or treat any disease or condition other than vertebral Subluxation. However if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend our patients seek care fro a health care provider who specializes in that area. Regardless of the specific condition we cannot provide care of give advice on the care provided by other practitioners.

Our Practice objective is to eliminate major interference to the expression of the body's innate wisdom.

All questions regarding the doctor's objectives pertaining to my care in this office have been fully answered.

_____

Print Name

_____ _____

Sign Name **Date**

Chiropractic Center of Lakeland

The claims for treatment for my current condition which the Doctor will diagnose with an onset date of _____, is ***not*** related to an automobile accident, workers compensation claim or any other accident involving a third party or payor.

If you have any question please ask a Chiropractic Center of Lakeland Staff member.

_____

Print Name

_____ _____

Sign Name **Date**

Chiropractic Center of Lakeland

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or canceled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your canceled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses—you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or canceled appointments, please realize how important it is to keep your reserved time. However, if you are scheduled for a Massage, a $25 cancellation fee is enforced for the inconvenience of others. Thank you for your consideration of our policies and the opportunity to be your chiropractic office of choice.

_____ _____

Signature Date