Lake Wylie Family Chiropractic

Welcome to our office! Please complete each page to the best of your ability. Please ask if you need any help.

ABOUT YOU
(Some of the information requested here we are required by law to collect as a primary care facility. It has no relevance to the care you will receive at this office)

Today's Date: ____/____/_______ **Whom may we thank for your referral?**___________

Patient Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_________________________**Nick Name**_______ _______________________

Last Name_________________________**Middle Name** _______________**Suffix** ______

Address ____

City_______________________________ **State**_____________**Zip Code** _____________

Primary Phone _____________________**Secondary Phone** ________________________

Home e-Mail:______________________ **Work e-Mail:** ____________________________

Which email address shall we communicate with you? *(check one)* ❑ Home ❑ Work

Preferred Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Home Email ❑ Work Email

Date of Birth:___/___/______ **Age**______ **Gender**: ❑ Male ❑ Female ❑ Unspecified

Marital Status ❑ Single ❑ Married ❑ Other **SSN:** _______-_______-_________

Employment Status:

❑ Employed ❑ F/T Student ❑ F/T Student ❑ Retired ❑ Other

Employer: ______________________________Occupation: ________________________

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Hawaiian or Pacific Islander
❑Samoan ❑ Guamanian/Chamorro ❑Other________❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑English ❑Spanish ❑American Sign Language ❑Chinese ❑French ❑German
❑Tagalog ❑Vietnamese ❑Italian ❑Korean ❑Russian ❑Polish
❑Arabic ❑Portuguese ❑Japanese ❑French Creole ❑Greek ❑Hindi
❑Persian ❑Urdu ❑Gujarati ❑Armenian ❑I choose not to specify

Verification Question *(Please choose a question that we can use to verify your identity when we communicate with you and give the answer to that question in the space provided)*

❑ What's the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question:______________________________________

Emergency contact person:___________________________ **Phone:**________________

Insurance Policy Holder *(if this is some one other than you please provide their name and details. If you are the policy holder place write "self")*

Name:________________________________ **D.O.B.:**___________________

Employer:____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with____
Name of Insurance Company

and assign directly to Lake Wylie Family Chiropractic all medical 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 my insurance. I hereby authorize Lake Wylie Family Chiropractic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Lake Wylie Family Chiropractic's staff may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ ____________________
Signature of Patient/Parent/Guardian Date

____ ___________
Please print the name of Patient/Parent/Guardian Staff Initials

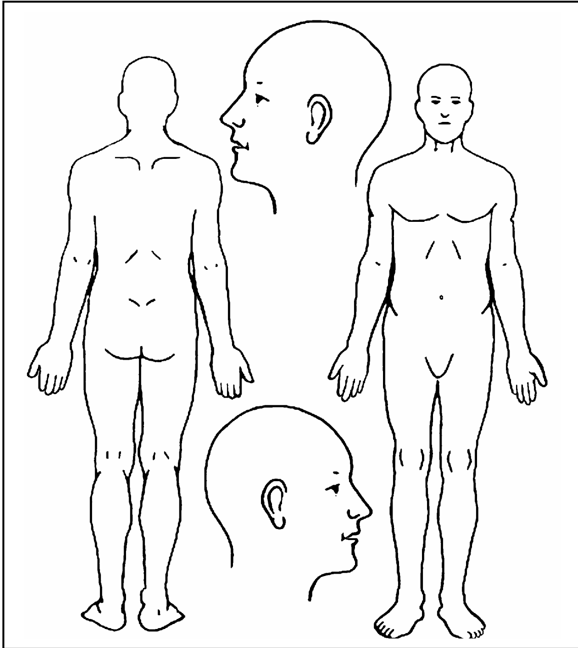
LAKE WYLIE FAMILY CHIROPRACTIC

CASE HISTORY

Full Name: ______________________________________ ☐ Male ☐ Female Birth Date: _________ Age: ______

1. DESCRIBE YOUR PRIMARY COMPLAINT: ____

____



What caused your complaint: ☐ Strain ☐ Fall ☐ Auto ☐ Work

☐ Stress ☐ Unsure ☐ Other (describe) ________________________

If work-related, was your employer notified? ☐ Yes ☐ No

If an Auto accident , please inform the front desk for additional forms

When did your symptoms start?: ______________________

Has this happened before?: ☐ Yes ☐ No If YES, When: __________

Onset of symptoms was: ☐ sudden ☐ gradual ☐ complex

Condition is: ☐ Worsening ☐ Improving ☐ Not changing

Quality of pain is: ☐ dull ☐ aching ☐ sharp ☐ shooting ☐ burning

☐ throbbing ☐ deep ☐ nagging ☐ tingling ☐ numb ☐ other: ____

Draw the location of ALL your symptoms on the diagram

When is the pain worse?____________________________________

Primary complaint: ☐ is constant ☐ comes and goes Frequency of symptoms:______________________________

Does any pain radiate or travel to any areas of your body?: ____

Do you have any numbness or tingling in your body?: ____

Grade your symptoms (worst and best) **:** **0 1 2 3 4 5 6 7 8 9 10**

No pain mild moderate strong severe

Does anything aggravate the complaint?: ____

Does anything make the complaint better?: ____

Complaint affects: ☐ Sleep ☐ Work ☐ Walking ☐ Exercise ☐ Dressing ☐ Social Activities ☐ Other_____________

Doctors you have seen for this condition: ________________________Imaging Studies?: ☐ No ☐ Yes - Date:______

What was their diagnosis and prescribed treatment?: ____

Has your condition responded to treatment?: (explain) ____

2. ANY SECONDARY COMPLAINTS?: ____

____

____

3. HEALTH HISTORY:

A. Co-morbidities (Other health issues that you are dealing with at this time):____________________

____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No

If yes, describe:____________________

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ____________________

B. Previous illnesses you've had in your life: ____________________

____

C. Previous Car accidents, injury or trauma: ____________________

____

D. Known Allergies (including drug allergies) and your reaction to them: *If none write "none"*

____

____

E. Medications: *If no current medications write "none"*

Medication you are now taking	Start date	Dosage	Reason for taking

F. Surgeries:

Date	Type of Surgery

G. Females:

Pregnancies/Date of Delivery	Outcome
______________________	____
______________________	____
______________________	____
______________________	____
______________________	____

What was the date of the beginning of your last menstrual period?: ___________________________________

5. FAMILY HEALTH HISTORY:

1. Associated health problems of blood relatives: ____

____

2. Cause of parents' or siblings' deaths — Age at death

Cause of parents' or siblings' deaths	Age at death
____	____________________________
____	____________________________
____	____________________________

6. SOCIAL AND OCCUPATIONAL HISTORY:

A. Level of Education: ☐ high school ☐ some college ☐ college graduate ☐ post graduate studies

B. Job description: ____

C. Work schedule: ____

D. Recreational activities: ____

E. Activity Level: ☐ sedentary ☐ moderate ☐ active ☐ very active

F. Alcohol Use ☐ Never ☐ Occasional ☐ Moderate ☐ Addiction ☐ Former Addiction

G. Tobacco Use ☐ Never ☐ Former Smoker ☐ Current every day smoker ☐ Current sometimes smoker

If you are a smoker, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

H. Drug use ☐ Denied ☐ Recreational ☐ Recovering addict ☐ Addict : Drug____________________

I. Diet ☐ Healthy ☐ Unhealthy ☐ Modified ☐ For Weight Loss Type:________________

To be performed by clinic staff:

Height: _________in. **Weight:**________ lbs **Sitting BP:** _______/_______mmHg

Doctor's Signature: ____ Date: _____/_____/_________

LAKE WYLIE FAMILY CHIROPRACTIC

SYSTEM REVIEW

Please check all conditions you currently have or have had

General Questions

- ☐ Weight loss
- ☐ Weight gain
- ☐ Change in sleep patterns
- ☐ Change in activity capacity

Neurologic and Psychiatric

- ☐ Anxiety
- ☐ Headaches
- ☐ Depression
- ☐ Meningitis
- ☐ Paralysis
- ☐ Seizure
- ☐ Stroke
- ☐ Tingling
- ☐ Tremors
- ☐ Memory Loss
- ☐ Fainting spells, dizziness
- ☐ Head injuries
- ☐ Blackouts or near blackouts
- ☐ Change in sensation anywhere on your body
- ☐ Localized weakness or numbness

Ears, Eyes, Nose & Throat

- ☐ Hay fever
- ☐ Glaucoma
- ☐ Polyps
- ☐ Allergy
- ☐ Cataracts
- ☐ Goiter
- ☐ Hoarseness
- ☐ Double vision
- ☐ Gum problems
- ☐ Eye problems
- ☐ Ear Infections
- ☐ Glasses/contacts
- ☐ Hearing Loss
- ☐ Ear discharge/pain
- ☐ Frequent nosebleeds
- ☐ Ringing in your ears
- ☐ Sinus infections
- ☐ Swollen glands

Cardiovascular

- ☐ Angina
- ☐ Chest Pain
- ☐ Leg cramps
- ☐ Murmurs
- ☐ Ankle swelling
- ☐ Awakening short of breath
- ☐ Cardiac catheterization
- ☐ Cold hands or feet
- ☐ Congenital heart defects
- ☐ Dizziness when standing quickly
- ☐ Heart attacks
- ☐ Heart failure
- ☐ High or low blood pressure
- ☐ Irregular heart rate
- ☐ Purple fingers or lips
- ☐ Leg pain that resolves with rest
- ☐ Heart palpitations
- ☐ Varicose veins

Respiratory

- ☐ Pleurisy
- ☐ Wheezing
- ☐ Asthma
- ☐ Breathlessness when lying flat
- ☐ Prolonged cough
- ☐ Coughing up blood
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Frequent infections (bronchitis)

Skin

- ☐ Abscess
- ☐ Dandruff
- ☐ Acne
- ☐ Oily skin
- ☐ Boils
- ☐ Rashes
- ☐ Hives
- ☐ Dry skin
- ☐ Lumps
- ☐ Jaundice
- ☐ Psoriasis
- ☐ Athlete's foot
- ☐ Excessive body odor
- ☐ Excessive sweating
- ☐ Fungal infections
- ☐ Nail problems
- ☐ Moles- irregular
- ☐ Moles - change/new

Kidneys & Urinary Tract

- ☐ Blood in urine
- ☐ Brown urine
- ☐ Dribbling after urination
- ☐ Painful urination
- ☐ Excessive thirst
- ☐ Involuntary urination/incontinence
- ☐ Urinating frequently (day)
- ☐ Urinating frequently (night)
- ☐ Urine hesitancy
- ☐ Weak flow
- ☐ Frequent bladder infections
- ☐ Kidney disease
- ☐ Kidney stone

Endocrine

- ☐ Diabetes
- ☐ Sickle cell
- ☐ Abnormal body hair
- ☐ Changes in skin texture
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ History of "borderline" diabetes
- ☐ Increased loss of hair
- ☐ Rheumatism
- ☐ Thyroid disease

Male & Female

- ☐ Painful sexual intercourse
- ☐ Loss of sexual interest
- ☐ Unprotected sex
- ☐ Groin itching
- ☐ Sexually transmitted diseases

☐ Males Only

- ☐ Hernia
- ☐ Bloody ejaculation
- ☐ Inability to complete intercourse
- ☐ Lump on testicle
- ☐ Penile discharge
- ☐ Sterility
- ☐ Sores on penis or warts
- ☐ Prostate disease
- ☐ Testicular pain
- ☐ Testicular swelling

Musculoskeletal

- ☐ Anemia
- ☐ Arthritis
- ☐ Back pain
- ☐ Bursitis
- ☐ Gout
- ☐ Joint aches
- ☐ Neck pain
- ☐ Tendonitis
- ☐ Abnormal Blood Counts
- ☐ Blood clots in legs/lungs
- ☐ Bone Marrow Biopsy
- ☐ Easy Bleeding
- ☐ Easy bruising
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Muscle aches

Gastrointestinal

- ☐ Diarrhea
- ☐ Gallstones
- ☐ Reflux
- ☐ Vomiting
- ☐ Ulcers
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Indigestion
- ☐ Abdominal pain
- ☐ Anal fissures
- ☐ Black tarry stools
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Nausea
- ☐ Problems swallowing
- ☐ Hiatal Hernia
- ☐ Intestinal obstruction
- ☐ Liver disease
- ☐ Hemorrhoids
- ☐ Red blood after bowel movement

☐ Females Only

- ☐ D + C
- ☐ Hot flashes
- ☐ Hernia
- ☐ Fibroids
- ☐ Endometriosis
- ☐ PMS
- ☐ Abn. bleeding between cycles
- ☐ Abnormal pap smear
- ☐ Bleeding after intercourse
- ☐ Complications with pregnancy
- ☐ Heavy bleeding during cycles
- ☐ Ovarian cysts
- ☐ Pelvic Inflammatory Disease
- ☐ Postmenopausal symptoms

Provider Notes:

Patient Signature   Date   Provider Signature   Date

By signing this document you attest to the truth and accuracy of this health survey.

LAKE WYLIE FAMILY CHIROPRACTIC

Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by **Lake Wylie Family Chiropractic** or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. A copy of the Notice is available in the waiting room.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

______________________________	______________
Patient or Legally Authorized Individual Signature	Date
______________________________	______________
Print Patient's Full Name	
______________________________	______________
Witness Signature	Date

Optional authorizations (Please initial/complete the following as you choose):

1 - You have my permission to leave me a voice mail message if the need arises _______

2 - You may discuss my health information with the following people (please indicate the names of family members or friends):

____

____

Informed Consent To Chiropractic Treatment

A doctor of chiropractic locates, analyzes and treats joint fixation, segmental dysfunction (collectively called a vertebral subluxation complex) and soft tissue lesions. The primary methods the doctor and his associates will use to treat you will be spinal adjustments, myofascial release (trigger point therapy) and exercise therapies. Ancillary therapies used to complement your treatment may include decompressive traction, electrical stimulation, ultrasound and manual therapies.

Chiropractic Treatment:

The doctor will use his/her hands or a mechanical device in order to move the joints. You may feel a “click” or a “pop” such as the noise created when a knuckle is “cracked”, and you may feel movement of the joint. In addition, our doctors employ myofascial release methods both before and after they adjust you. Myofascial release techniques require the doctor to push and stretch the muscles to cause them to elongate and release, which may occasionally cause superficial bruising.

Risk Associated With Chiropractic Treatment:

As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications.

Risk Probabilities:

The risks of complications due to chiropractic treatment have been described as “rare”, (Haldeman, Scott, MD, DC), about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Alternative Treatment Options:

1. Self treatment to include over the counter medication.
2. Medical treatment to include the use of prescription drugs and physical therapy.
3. Surgery.
4. Hospitalization.

If Doctor Hartley believes that such interventions are warranted he will make that recommendation

Risks Of Alternative Treatment:

1. Overuse and improper dosage of over the counter medications may produce undesirable side effects.
2. Overuse and improper dosage of prescribed medications can lead to undesirable side effects and drug dependence.
3. Risks associated with surgery include adverse reactions to anesthesia; surgical errors and protracted periods of convalescence.
4. Risks associated with hospitalization include expense, exposure to disease, and physician and staff errors and omissions.

Risk Of Not Receiving Chiropractic Treatment:

Risks associated with not receiving chiropractic treatment may include chronic symptomatology, 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, reduce activities of daily living and make future rehabilitation more difficult.

Consent To Receiving Chiropractic Treatment:

I hereby attest that this form has explained the nature and risks of spinal adjustments, the risk probabilities, alternative treatment options and their associated risks, and the risks of not receiving chiropractic treatment. I understand the risks involved in undergoing treatment and have of my own volition decided to undergo the treatment provided by Lake Wylie Family Chiropractic.

I hereby give my consent to chiropractic treatment at Lake Wylie Family Chiropractic.

Patient Name: ______________________________ Witness Name: ______________________________

Signature: ______________________________ Date: ______________ Witness Signature: ______________________________