

NEW PATIENT QUESTIONNAIRE

Name: _____ Age: _____ DOB: _____ Date: _____

Referring Physician: _____

Primary Care Physician: _____

Height: _____ Weight: _____ Are you: Right handed Left handed (please circle)

HISTORY:

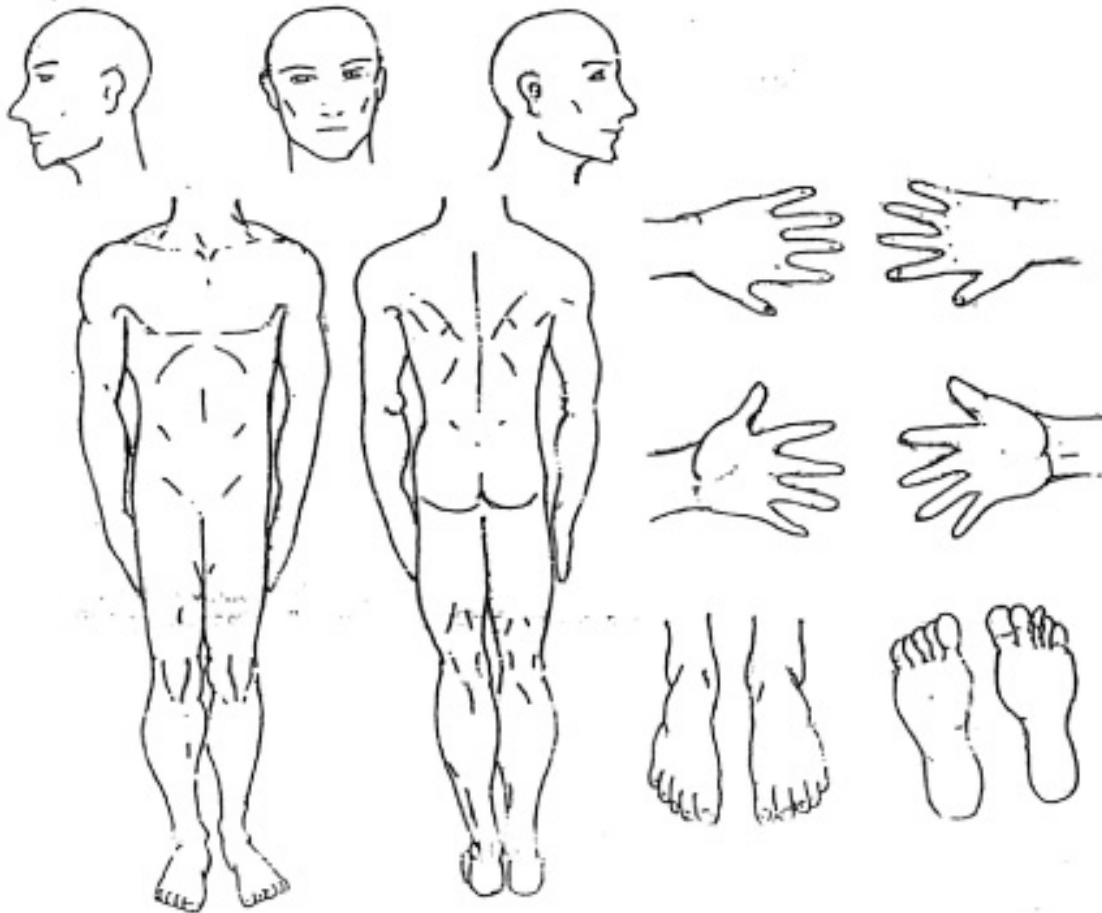
Chief Complaint: _____

Where is your pain located? _____

Describe your pain (circle all those that apply): sharp, burning, achy, twisting, pressure, deep, dull, heavy, gnawing, shooting, electric, knife-like

Please mark the figure with the location of your symptoms:

Pain=XX; Numbness/Tingling=OO



How severe is your pain (scale 0-10)? _____

0 Absent (No pain); **1-2** Tolerable (tolerate without medications); **3-4** Bearable (some activities restricted/prevented, requires medication); **5-6** Nearly intolerable (sedentary, only able to watch TV, read, etc.); **7-8** Intolerable (Can't read, watch TV, use the phone, need to visit ER for pain killers); **9-10** Devastating (need hospitalization for pain control)

|-----| (please draw a line through where you feel your
0 10 your pain is best represented)

How long have you had your pain? _____

When do you have your pain? _____

What makes your pain better? _____

What makes your pain worse? _____

Are you having difficulty with sleep because of your pain? _____

How long can you: Sit _____ **Stand** _____ **Walk** _____

Have you lost any control over bowel or bladder functions? YES NO (please circle)

Is your pain related to a specific injury? YES NO (please circle)

If yes, please describe: _____

Is the injury/pain motor vehicle related? YES NO (please circle)

If yes, what was the date of your accident? _____

Is the injury/pain work related? YES NO (please circle)

Is there a lawsuit (pending or considered)? N/A YES NO (please circle)

Have you been treated by other clinicians for this problem? YES NO (please circle)

If Yes, please list name, date seen, and treatment given: _____

Have you had any physical therapy (PT)? YES NO (please circle)

How many sessions? _____ **Has PT helped?** YES NO (please circle)

Have you had epidural or facet injections? **YES** **NO** (please circle)
How many? _____ Did they help? **YES** **NO** (please circle)

Have you had a previous back or neck surgery? **YES** **NO** (please circle)

Have you had diagnostic tests performed (CT, MRI, EMG, etc.)? **YES** **NO** (please circle)
If Yes, please list: _____

What do you hope we can accomplish today? _____

WORK HISTORY:

Are you working? **YES** **NO** (please circle)

If so, Full-time _____ Part-time _____ Restricted Duty _____

If restrictions, please describe: _____

If not, date last worked: _____

Occupation: _____ Employer: _____ How long in position? _____

MEDICATIONS:

List all medications that you are currently taking: _____

List medications that you have taken in the past and if they did or did not help: _____

Medication allergies? **YES** **NO** (please circle)

Please list: _____

PAST MEDICAL HISTORY:

Please place an "X" by any of the following illnesses you have or had:

| | | | |
|----------------------------|-------------------------|-------------------------------|---------------------|
| Anxiety _____ | Depression _____ | Psychiatric problem _____ | Asthma _____ |
| Pneumonia _____ | Lung Disease _____ | Pulmonary Embolism _____ | Heart Disease _____ |
| Heart Murmur _____ | Heart Attack _____ | High Blood Pressure _____ | Anemia _____ |
| High Cholesterol _____ | Bleeding Disorder _____ | Deep Vein Thrombosis _____ | GERD _____ |
| Ulcers _____ | Rheumatic Fever _____ | Liver Disease/Hepatitis _____ | Alcoholism _____ |
| Arthritis _____ | Muscle Disease _____ | Thyroid disorder _____ | Gout _____ |
| Diabetes _____ | Migraines _____ | Seizure Disorder _____ | Stroke _____ |
| Cancer _____ | HIV/AIDS _____ | Kidney Disease _____ | Tuberculosis _____ |
| Rheumatoid Arthritis _____ | Psoriasis _____ | Other _____ | |

PAST SURGICAL HISTORY:

Please list any previous surgeries: _____

FAMILY HISTORY:

Please list any medical illnesses that the following blood relatives have a history of:

Grandparents: _____

Living or deceased _____

Father: _____

Living or deceased _____

Mother: _____

Living or deceased _____

Brothers/Sisters: _____

Living or deceased _____

SOCIAL HISTORY:

Marital Status: Single Married Divorced Separated Widow (please circle)

Number of children _____ Ages _____

Do you smoke? No Yes How much? _____ For how long? _____

Previous Smoker? No Yes When did you quit? _____

Do you drink alcohol? No Yes How many drinks per week? _____

Do you use recreational drugs? No Yes If yes, what type: _____

REVIEW OF SYSTEMS: Please mark an "X" for Yes and leave blank for No.

CONSTITUTIONAL: I have none of the symptoms listed _____

Fever _____ Chills _____ Fatigue _____ Night Sweats _____

Unexplained weight Gain/Loss _____

SKIN: I have none of the symptoms listed _____

Rashes _____ Nail changes _____ Easy Bruising _____ Color changes _____

Jaundice _____ Infections _____

EYES/EARS/NOSE/THROAT: I have none of the symptoms Listed _____

Vision changes _____ Hearing Loss _____ Dizziness/Vertigo _____ Ringing in the ear _____

Hoarseness _____ Difficulty Swallowing _____ Discharge/Drainage _____

CARDIOVASCULAR: I have none of the symptoms listed _____

Chest Pain _____ Palpitations _____ Leg Swelling _____

RESPIRATORY: I have none of the symptoms listed _____

Coughing up blood _____ Wheezing _____ Shortness of Breath _____ Cough _____

Sputum Production _____ Recent Infection _____

GASTROINTESTINAL: I have none of the symptoms listed _____
Abdominal pain _____ Vomiting w/wo blood _____ Nausea _____ Blood in stool _____
Constipation _____ Diarrhea _____

GENITOURINARY: I have none of the symptoms listed _____
Painful urination _____ Blood in urine _____ Venereal Disease _____ Difficult urination _____
Sexual problems _____ Menstrual Problems _____ Pregnant _____ Menopausal _____

MUSCULOSKELETAL: I have none of the symptoms listed: _____
Joint swelling _____ Stiffness _____ Cramping _____ Infection _____

ENDOCRINE: I have none of the symptoms listed _____
Changes in urination _____ Changes in heat or cold intolerance _____
Changes in appetite/thirst/sweating _____

PSYCHIATRIC: I have none of the symptoms listed _____
Depression _____ Anxiety _____ Suicidal Thoughts _____ Mood Changes _____

PATIENT SIGNATURE _____ **Date:** _____

PHYSICIAN SIGNATURE _____ **Date:** _____

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 Laney Chiropractic Center or 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. You may request a copy of the Notice at the Front Desk.

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.

Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Name of Patient (Print)

Signature of Patient

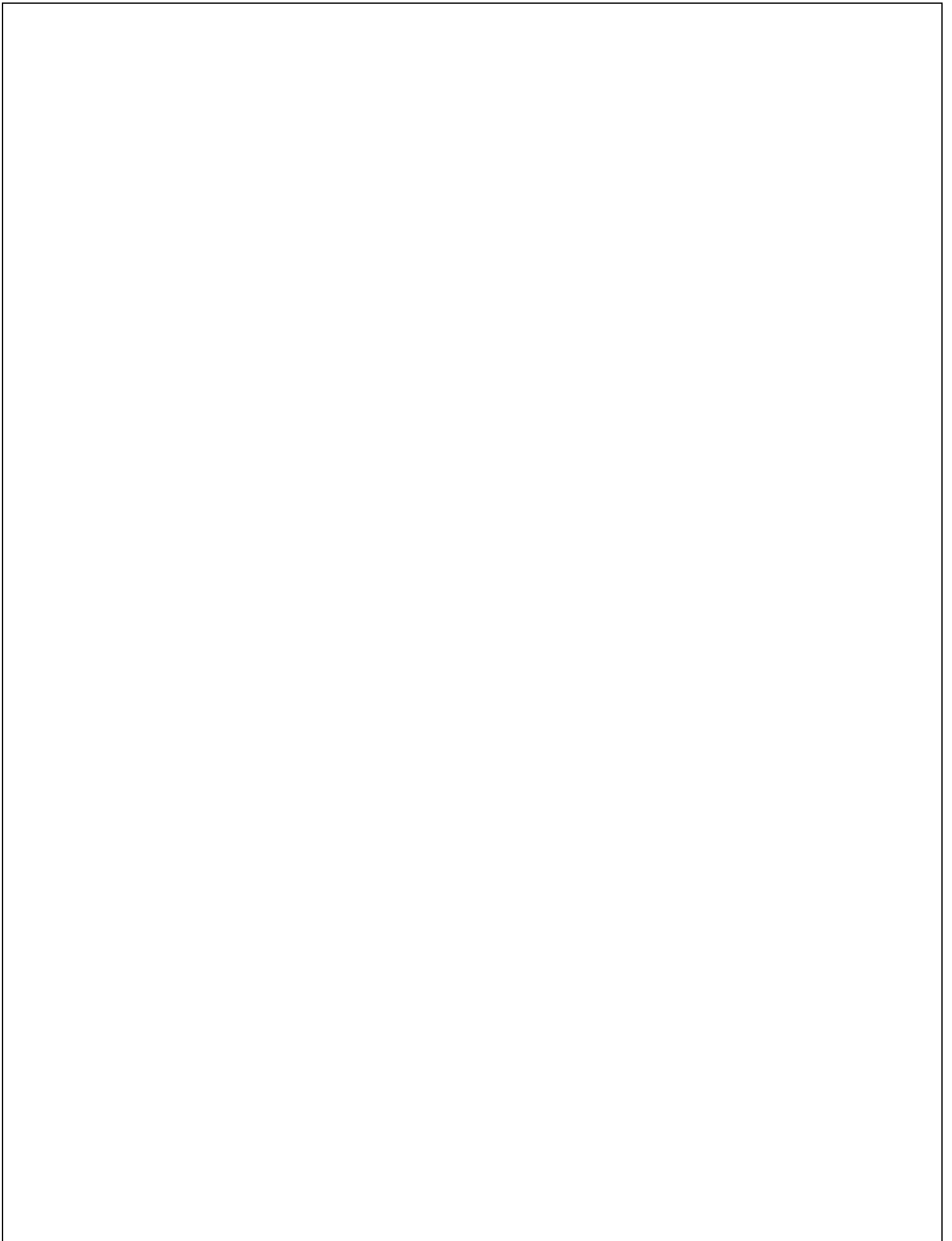
Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

Office Representative

Date



INFORMED CONSENT DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor **before** signing the statement of policy.

I have read and understand the foregoing.

DATE

SIGNATURE

OFFICE POLICY ON FEES AND INSURANCE CLAIMS

If, by mutual agreement, we are filing your insurance, we need to inform you that you are entering a relationship with the doctor in which the doctor agrees to treat the patient and the patient agrees to pay the doctor's fee for that treatment. The insurance company has no relationship with the doctor. If we contact your insurance company and are informed that insurance benefits are available for the treatment recommended, we will file your claim for you. We are responsible only to file your claim and answer any medical questions they may have.

Insurance companies give estimates and benefits over the telephone, but these are only estimates and are not always accurate nor a guarantee of payment. You will be responsible for your yearly deductible, co-payment and/or co-insurance and the portion of the charges your insurance carrier does not cover or lists as a "non covered" expense. If your insurance company does not pay within sixty (60) days, your bill is due and payable immediately.

Name (please print)

Date

Signature of Responsible Party

ASSIGNMENT AND RESPONSIBILITY

I hereby assign to Dr. Laney, Dr. Johnson and/or Dr. Hoyt all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with my insurance company. I further permit a copy of this authorization to be used in place of the original. **I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.** If the insurance company does not pay within sixty (60) days, I understand the balance is due immediately and agree to pay in full.

Signature of Responsible Party

Date

OUT OF NETWORK

I understand that Dr. Laney, Dr. Johnson and/or Dr. Hoyt are not preferred providers for my insurance company and that out of network benefits will apply. This may include, but not limited to, such things as a deductible, higher deductible and/or higher co-pay, reduced benefits.

Signature of Responsible Party

Date

