# *Confidential Patient Information*

Name_____ Home Phone_____ Work_____
Address_____ City_____ State_____ Zip_____
Date of Birth_____ Marital Status (Circle) M ○ S ○ D ○ W ○ Age_____
Social Security Number_____ E-mail Address_____
Occupation_____ Employer_____
Work Address_____ City,St,Zip_____
Spouse's Name_____ # Children_____
Who may we thank for referring you to our office?_____
Have you ever had Chiropractic before? Yes ☐ No ☐ Date_____

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Is this injury or illness related to: Employment ☐ Auto Accident ☐
Date: _____ Location: _____
Workers Compensation Ins. Co._____ Phone_____
Your Auto Insurance Co._____ Phone_____
Third Party Auto Insurance Co._____ Phone_____

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Do you have Health Insurance Yes ☐ No ☐ Subscribers Soc. Sec. #_____
Primary Insurance Company_____ Phone_____
Secondary Insurance Company_____ Phone_____

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All Charges are due when services are rendered. . . . . .
Method of payment (☐) Check (☐) Cash (☐) Credit Card (☐) Care Credit

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Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

**RELIEF CARE**
Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

**CORRECTIVE CARE**
Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

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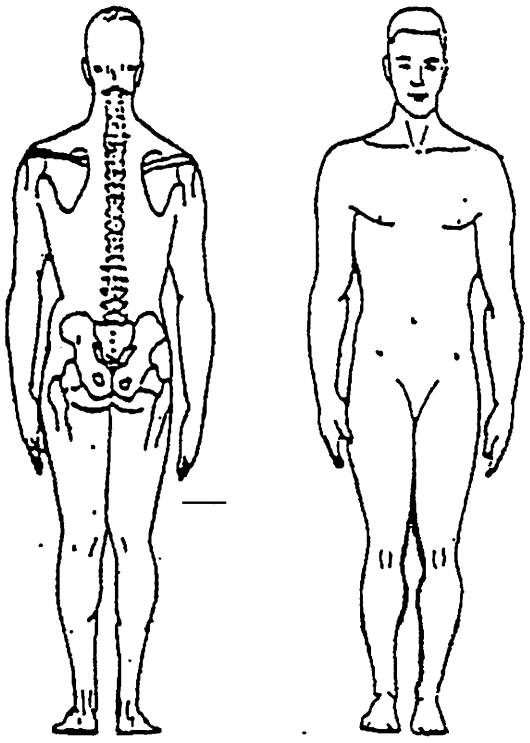
I authorize Lark Family Chiropractic Center to render necessary services to me and I am responsible for all charges incurred.
Patient
Signature_____ Date_____
Guardian or spouse's authorizing care_____

*Thank You For Allowing Us To Serve You!*

*PLEASE MARK AN X ON THE DIAGRAM*
*WHERE YOUR PROBLEMS ARE*



What hurts and how long has it hurt?

_____
_____
_____
_____

List your chief complaints in order of severity

1._____
2._____
3._____
4._____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

_____
_____
_____
_____

Check any of the following you have had in the last six months:

| | | | |
|---|---|---|---|
| ☐ | Headaches | ☐ | Numbness |
| ☐ | Sinus Congestion / Allergies | ☐ | Frequent Nausea / Vomiting |
| ☐ | Vision Problems | ☐ | Abdominal Cramps |
| ☐ | Ear aches | ☐ | Constipation |
| ☐ | Dizziness | ☐ | Diarrhea |
| ☐ | Heart Problems | ☐ | Poor / Excessive Appetite |
| ☐ | Lung Problems / Congestion | ☐ | Excessive Thirst |
| ☐ | Blood Pressure Problems | ☐ | Painful / Excessive Urination |
| ☐ | Ankle Swelling | ☐ | Discolored Urine |
| ☐ | Prostate / Sexual Dysfunction | ☐ | Diabetes |
| ☐ | Menstrual Cycle Dysfunction | ☐ | Cancer |

What do you hope to get from chiropractic care? _____

Are you pregnant? (☐) Yes (☐) No (☐) Not Sure

# FAMILY HEALTH HISTORY

Patient_____ Date_____

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation of **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

| | FATHER AGE___ | MOTHER AGE___ | SPOUSE AGE___ | BROTHER(S) AGE___ | BROTHER(S) AGE___ | SISTER(S) AGE___ | SISTER(S) AGE___ | CHILDREN AGE___ | CHILDREN AGE___ | CHILDREN AGE___ |
|---|---|---|---|---|---|---|---|---|---|---|
| **First Name** | | | | | | | | | | |
| **Condition** | | | | | | | | | | |
| Arthritis | | | | | | | | | | |
| Asthma - Hay Fever | | | | | | | | | | |
| Back Trouble | | | | | | | | | | |
| Bursitis | | | | | | | | | | |
| Cancer | | | | | | | | | | |
| Constipation | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Disc Problems | | | | | | | | | | |
| Emotional Problems | | | | | | | | | | |
| Emphysema | | | | | | | | | | |
| Epilepsy | | | | | | | | | | |
| Headaches | | | | | | | | | | |
| Heart Trouble | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | |
| Insomnia | | | | | | | | | | |
| Kidney Trouble | | | | | | | | | | |
| Liver Trouble | | | | | | | | | | |
| Migraine | | | | | | | | | | |
| Nervousness | | | | | | | | | | |
| Neuritis | | | | | | | | | | |
| Pinched Nerves | | | | | | | | | | |
| Scoliosis | | | | | | | | | | |
| Sinus Trouble | | | | | | | | | | |
| Stomach Trouble | | | | | | | | | | |
| Other: | | | | | | | | | | |
| | | | | | | | | | | |

# 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 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 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. The patient understands and agrees to allow this chiropractic office to contact them via electronic means such as through phone, fax, email, etc.

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 healthcare provider 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.

_____ _____

Name of Patient Date

# Informed Consent for Chiropractic Care

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become informed prior to beginning care.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and rarely, fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence *does not* establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

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I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

| | |
|---|---|
| Patient Name or legal Guardian(printed) | Date |
| Patient or legal Guardian Signature | Relationship to patient |
| Witness Signature (office staff) | Date |

# Lark Chiropractic
## Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one primary goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic methods of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of disease of infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission os mental impulses, resulting in a lessening of the body's innate ability to express it's maximum potential.

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. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of health care provider who specializes in that area.

Regardless of what the disease is called , we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR PRIMARY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I _____have read and fully understand the above statements.

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

I therefore accept chiropractic care on this basis.

_____ _____

(Patient signature) (Date)