New Patient Information

Personal Information

Name	Today's Date
Street Address	Date of Birth
City | State | Zip	Gender
Email	Phone
Occupation	Marital Status
Family member name(s) and age(s)	
How did you hear about Lake Life Chiropractic?	

Current Health Concern(s)

Health Concern *in order of importance*	Present Severity 1-10	How long have you had this?	Did this start with an injury? Y/N	Is this constant or does it come and go?
1.				
2.				
3.				

❑ *I do not have any current health conditions and seek wellness / maintenance / preventative care.*

Information regarding your **primary** health concern:

What makes the condition better? What makes this condition worse?

Are you seeing any other providers for this condition? **Y / N** If yes, who?

How does this condition affect your daily life?

❑ Carrying groceries	❑ Lift/play with children	❑ Static standing	❑ Yard work
❑ Sitting to standing	❑ Read or concentrate	❑ Walking	❑ Garbage
❑ Climbing stairs	❑ Shower	❑ Sweep/vacuum	❑ Dress
❑ Caring for pets	❑ Shave	❑ Dishes	❑ Drive
❑ Computer use	❑ Extended sitting	❑ Laundry	❑ Sleep

Have you been to a chiropractor before? Y / N If yes, who & when? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment to restoring your health: _____

Did/Do you have any of the following?

Stroke Cancer Heart Disease Spinal Surgery Seizures Spinal Bone Fracture

Other Health Concerns/Conditions

- ❑ Acid Reflux
- ❑ ADD/ADHD
- ❑ Anxiety
- ❑ Arm Pain
- ❑ Asthma
- ❑ Autism
- ❑ Chest Pain
- ❑ Chronic Fatigue
- ❑ Chronic Sinus
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Ear Infections
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Headaches
- ❑ High Blood Pressure
- ❑ Hip Pain
- ❑ Incontinence
- ❑ Infertility
- ❑ Irritable Bowel
- ❑ Kidney Problem
- ❑ Knee Pain
- ❑ Leg Pain
- ❑ Liver Disease
- ❑ Low Back Pain
- ❑ Lupus
- ❑ Menstrual Disorder
- ❑ Migraines
- ❑ Mid Back Pain
- ❑ Nausea
- ❑ Neck Pain
- ❑ Nervousness
- ❑ Numbness in hands
- ❑ Numbness in arms
- ❑ Numbness in legs
- ❑ Numbness in feet
- ❑ Sciatica
- ❑ Shoulder Pain
- ❑ Stomach Disorder
- ❑ Thyroid Problems
- ❑ TMJ
- ❑ Ulcers
- ❑ Vertigo
- ❑ _____

History of Physical, Chemical + Emotional Stress

Have you had any significant falls, surgeries, or other injuries? Y / N
If yes, please describe:

Have you been in any auto accidents? Y / N
If yes, please describe:

Please list any medications or supplements you are currently taking:

Do you consume any of the following on a consistent basis? Please circle:

Cigarettes Alcohol Processed Foods Sugar Gluten Dairy

How would you rate your level of physical activity on a weekly basis?

1 2 3 4 5 6 7 8 9 10
sedentary moderately active highly active

How would you rate your quality of sleep?

1 2 3 4 5 6 7 8 9 10
low moderate high

How would you rate your current level of emotional stress?

1 2 3 4 5 6 7 8 9 10
low moderate high

Patient Name: _____ **Date:** _____

Oswestry Disability Index

This questionnaire has been designed to give the doctor(s) information as to how your pain or condition has affected your ability to manage everyday life. Please answer every section and circle in each section **the ONE number** that most closely applies to you and describes your problem.

Section 1: Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is very severe.
5. The pain is severe and does not vary much.

Section 2: Personal Care

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain, I am unable to do some washing and dressing without help.
5. Because of the pain, I am unable to do any washing and dressing without help.

Section 3: Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
3. Pain prevents me from lifting heavy weights off the floor.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at the most.

Section 4: Walking

0. I have no pain on walking.
1. I have some pain on walking, but it does not increase with distance.
2. I cannot walk more than one mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5: Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than one hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain right away.

0-10	Minimal disability
11-20	Moderate disability
21-30	Severe disability
31-40	Crippled (incapacitated)
41-50	Bed-bound

Section 6: Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing, but it does not increase with time.
2. I cannot stand for longer than one hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain right away.

Section 7: Sleeping

0. I get no pain in bed.
1. I get pain in bed, but it does not prevent me from sleeping well.
2. Because of pain, my normal night's sleep is reduced by less than ¼.
3. Because of pain, my normal night's sleep is reduced by less than ½.
4. Because of pain, my normal night's sleep is reduced by less than ¾.
5. Pain prevents me from sleeping at all.

Section 8: Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal, but increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing).
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9: Traveling

0. I get no pain while traveling.
1. I get some pain while traveling, but none of my usual forms of travel makes it any worse.
2. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3. I get extra pain while traveling, which compels me to seek alternative forms of travel.
4. Pain restricts all forms of travel.
5. Pain prevents all forms of travel except that done lying down.

Section 10: Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates, but is definitely getting better.
2. My pain seems to be getting better, but improvement is slow at present.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Patient Name: _____ **Date:** _____

Terms of Acceptance

Part of our role is to provide you with information to assist you in making informed choices. Chiropractic care centrally involves what is known as the chiropractic adjustment. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures.

It is important to understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures, disc injuries, strains and sprains. With respect to strokes, the reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the GI tract was 1219 events per one million and risk of death has been estimated as 104 per one million users.

It is also important to understand there are treatment options available for your condition other than chiropractic procedures. These treatment options include, but are not limited to over the counter analgesics, rest, prescription drugs, potential surgeries. Understand that you have the right to a second opinion.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I hereby request and consent to the performance of chiropractic procedures on me (or on the patient named below, of whom I am legally responsible) by the licensed chiropractors at Lake Life Chiropractic. I intend this consent to cover the course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Signature _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

> Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; obtain payment from third-party payers; and conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation.

Signature _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of the x-rays in our files.
Please Note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate medical pathology. The doctors of Lake Life Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

FEMALE PATIENTS: To the best of my knowledge, I believe I am not pregnant at the time x-rays are taken. _____ (initial)

FEMALE PATIENTS: I am pregnant at this time and understand x-rays will not be taken today. _____ (initial)

Signature _____

Assignment of Benefits

I assign the rights and benefits of all applicable third party payments to Lake Life Chiropractic for the service and supplies rendered during the course of my treatment. I agree to pay any deductible or copayment not covered by my insurance company, and further authorize the release of medical information as necessary to process my claims. I understand that any claims denied by the insurance company become my financial responsibility.

This assignment of benefits form includes all rights to collect benefits from the insurance company for services I have received. Additionally, I authorize Lake Life Chiropractic all rights to proceed against the insurance company obligated to provide benefits in any action in which the insurance company fails to make payment that is due. This includes filing complaints directly to the insurance commissioners in the state I receive treatment and the state where the insurance company is physically located. Should Lake Life Chiropractic receive any checks made payable to said provider and myself, I authorize endorsing and depositing the check as is standard business practice of my provider.

Signature _____

Patient Name: _____ **Date:** _____