New Patient Health Record

JASON LAUER
LAUER FAMILY CHIROPRACTIC

About The Patient

Name: _____

Address: _____

City: _____ State: _____

Zip: _____ DOB: _____

Phone: _____ Cell: _____

Email: _____

Age: _____Gender: _____ Number of Children: _____

Employer: _____

Work Address: _____

Work Phone: _____

Type of Work: _____

Marital Status: _____

Payment Method: ☐ Check ☐ Cash ☐ Credit

About The Spouse

Name: _____

Employer: _____

Work Phone: _____

Type of Work: _____

Experience With Chiropractic

Who may we thank for referring? _____

How did you hear about us? ☐ Google search

☐ Social Media ☐ Lecture Guest ☐ Referred ☐ Location

Have you been seen by a Chiropractor before? Y☐ N☐

Reason for those visits? _____

Doctor's Name: _____

Approximate last visit there: _____

Has anyone in your family been seen by a Chiropractor?
Y☐ N☐

Reason For This Visit

How can we help you today?_____

_____

Is this appointment related to: ☐ Job ☐ Auto ☐ Neither?

If job related, have you reported this to your employer?
Y☐ N☐

When did this condition begin? _____

What helps? _____

What worsens? _____

Since your condition started, has it:

☐Worsened ☐No change ☐Improved?

What are you unable to do because of this condition?

_____

Have you had this condition in the past? Y☐ N☐

Please explain: _____

Have you been evaluated by other providers for this?

If so, who: _____Dates: _____

Type of treatment and results achieved:_____

_____

Health Habits

Do you smoke/vape: Y☐ N☐

Drink alcohol: Y☐ N☐

Drink coffee/energy drinks: Y☐ N☐

Do you wear: ☐ Arch Supports ☐ Heel Lifts?

Exercise Regularly: Y☐ N☐

What type and frequency of exercise? _____

_____

Participate in a nutrition or weight loss program? If so which one? _____

Supplements:_____

_____

Do you have interest in supporting your condition by learning more about exercise and nutrition?

Y☐ N☐

Goals For My Care

People visit Chiropractors for a variety of reasons. Some go for pain relief, some to correct the cause of pain, and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care you desire so that we may be guided by your wishes whenever possible.

☐ **Relief care** – Symptomatic relief of pain or discomfort

☐ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptom

☐ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care. I want the Doctor to select the type of care that is most appropriate.

Please circle below the health concern or concerns you have now or have had in the past. Each area of concern relates to an area of the spine and related nerve function.

Stiff Neck
Sore throat
Radiating Arm Pain
Arm/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Condition

Headaches
Migraines-Dizziness
Sinus Problems
Allergy-Fatigue
Frequent Colds
Vision Problems
Trouble Concentrating
Hearing Problems

Mid Back Pain
Difficulty Breathing
Frequent Chest Infection
Indigestion/Reflux
Poor Digestion
Ulcers
Kidney Problems

Constipation
Diarrhea
Abdominal Pain
Bladder
Menstrual
Lower Back Pain
Pain or Numbness in Legs
Reproductive

Other:_____
_____
_____
_____
_____
_____
_____

Medications

☐ Stimulants
☐ Antianxiety
☐ Antidepressant
☐ ADHD
☐ Immunologic Therapy
☐ Blood Pressure
☐ Cholesterol
☐ Blood Thinners
☐ Pain Killers (including over the counter)
☐ Diabetes
Others:_____
_____

For Women

Are you pregnant? Y☐ N☐
Are you nursing? Y☐ N☐
On birth control? Y☐ N☐
Irregular cycles? Y☐ N☐

Breast implants? Y☐ N☐
Cosmetic implants? Y☐ N☐
Painful menstrual cycles? Y☐ N☐
Hormone Replacement? Y☐ N☐

Health Conditions

Please check each of the diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall evaluation, care plan, and the possibility of being a candidate for care.

☐ Neck pain
☐ Severe or frequent headaches
☐ Heart surgery/pacemaker
☐ Heart attack
☐ Heart problems
☐ Breathing difficulty
☐ Asthma
☐ Loss of sleep
☐ Mid back pain
☐ Digestive problems
☐ Ulcers
☐ Colitis/Chron's/IBS
☐ Kidney problems
☐ Arthritis
☐ Diabetes
☐ Sinus problems
☐ Lower back pain
☐ Dizziness
☐ Stroke
☐ Chemotherapy
☐ Numbness/Tingling
☐ Frequent infections
☐ Immune complications
Other:

Please list all surgeries

Authorization For Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

_____ _____

Signature Date

_____ _____

Guardian or Spouse's Signature Authorizing Care Date

Who should receive bills for payment on your account?

☐ **Patient** ☐ **Spouse** ☐ **Parent** ☐ **Worker's Comp** ☐ **Auto Insurance** ☐ **Medicare Health Insurance**

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray image will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

Terms of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

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

Health is a state of optimal physical, mental, and social wellbeing, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

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 evaluation, 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 a 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 ONLY 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 statement. Any 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's Signature _____Date_____

Witness_____

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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

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

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed. Patient Name (Print):_____ Relationship to Patient:_____

Signature:_____ Date:_____

Doctor's Notes:

CC1	
Loc	
O/past	
P	
Q	
R	
S	Now /10 Best /10 Worst /10
T	AM PM During Sleep

Notes:

CC2	
Loc	
O/past	
P	
Q	
R	
S	Now /10 Best /10 Worst /10
T	AM PM During Sleep

Notes: