LIFESTYLE CHIROPRACTIC
148 W. TIVERTON WAY, SUITE 140
LEXINGTON, KY 40503
PHONE: 859-271-(LIFE) 5433
FAX: 859-271-0050

PATIENT INFORMATION FORM

DATE: ___/____/____

PATIENT NAME: _____ DATE OF BIRTH: ___/___/___ AGE: _____

SEX: **M** **F** E-MAIL: _____

HOME ADDRESS: _____ CITY/STATE:_____ ZIP: _____

HOME PH. #:(____) ____-_____WORK PH. #:(____) ____-_____CELL PH. #:(____) ____-_____

EMERGENCY CONTACT PERSON: _____ RELATIONSHIP: _____

PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE #:(____) ____-_____

WHEN WAS YOUR LAST VISIT TO YOUR PRIMARY CARE DOCTOR AND FOR WHAT?_____

_____

LIST BELOW THE PERSON(S) YOU GIVE US PERMISSION TO SHARE YOUR CLINICAL INFORMATION WITH ?

NAME: _____NAME: _____

NAME:_____NAME: _____

HOW DID YOU HEAR OF OUR OFFICE OR WHO REFERRED YOU TO US? _____

HAVE YOU RECEIVED TREATMENT FROM A CHIROPRACTOR BEFORE? IF SO, WHEN AND FOR WHAT REASON?

_____

_____

PATIENT NAME: _____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____

_____

_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN THE SURGERIES NOTED ABOVE)

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

_____

_____

_____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

SPOUSES/PARTNER'S NAME_____

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENTLY USE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

EMPLOYER: _____ OCCUPATION: _____

DESCRIBE YOUR WORK DUTIES: _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPE(S) OF EXERCISE:_____

WHAT ARE YOU ALLERGIC TO? _____

FAMILY HISTORY

IS THERE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

YOUR MEDICAL HISTORY

WHAT ONGOING MEDICAL PROBLEMS/CONDITIONS ARE YOU PRESENTLY BEING TREATED FOR?

_____

_____

PATIENT NAME:_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?
CIRCLE THE CORRECT LETTER(S)

Y (YES) = HAD IT BEFORE
N (NO) = NEVER HAD IT
P (PRESENTLY) = HAVE IT NOW

ACID REFLUX	Y	N	P	FIBROMYALGIA	Y	N	P	NEUROPATHY	Y	N	P
ANEMIA	Y	N	P	GOUT	Y	N	P	OPEN SORES	Y	N	P
ARTHRITIS	Y	N	P	HEART ATTACK	Y	N	P	PNEUMONIA	Y	N	P
ASTHMA	Y	N	P	HEART DISEASE/FAILURE	Y	N	P	POLIO	Y	N	P
BACK TROUBLE	Y	N	P	HEPATITIS	Y	N	P	RHEUMATIC FEVER	Y	N	P
BLADDER INFECTIONS	Y	N	P	HIV+/AIDS	Y	N	P	SICKLE CELL DISEASE	Y	N	P
ABNORMAL BLEEDING	Y	N	P	HIGH BLOOD PRESSURE	Y	N	P	SKIN DISORDER	Y	N	P
BLOOD CLOTS	Y	N	P	KIDNEY DISEASE	Y	N	P	SLEEP APNEA	Y	N	P
BLOOD TRANSFUSION	Y	N	P	LIVER DISEASE	Y	N	P	STOMACH ULCERS	Y	N	P
BRONCHITIS/EMPHYSEMA	Y	N	P	LOW BLOOD PRESSURE	Y	N	P	STROKE	Y	N	P
CANCER	Y	N	P	MIGRAINE HEADACHES	Y	N	P	THYROID DISEASE	Y	N	P
DIABETES	Y	N	P	MITRAL VALVE PROLAPSE	Y	N	P	TUBERCULOSIS	Y	N	P
OTHER CONDITIONS:											

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

_____
_____
_____
_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES TO MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____

DATE: _____

***PATIENT NAME*_____**

LIST YOUR HEALTH CONDITIONS THAT YOU WOULD LIKE US TO HELP YOU WITH
(THE WORST ONE FIRST)

PROBLEM # 1: _____

WHEN DID THIS PROBLEM START? _____

HOW OFTEN DO YOU EXPERIENCE THIS PROBLEM?_____

HAVE YOU HAD THIS PROBLEM IN THE PAST? _____ IF YES, WHEN?_____

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION AND BY WHOM? _____

_____

WHAT CAUSED THIS PROBLEM; CAR ACCIDENT, WORK INJURY, OTHER TYPE INJURY, AGGRAVATION OR OLD INJURY, ETC?

_____

DESCRIBE WHERE YOU FEEL THE PAIN/PROBLEM_____

DID THIS PROBLEM: ☐ BEGIN SUDDENLY ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

RATE YOUR AVERAGE PAIN LEVEL ON A SCALE FROM 0 TO 10:

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (SERIOUSLY BAD PAIN!)

IS YOUR PROBLEM: ☐ STAYING THE SAME ☐ WORSENING ☐ IMPROVING

WHAT MAKES YOUR PAIN FEEL WORSE? _____

WHAT MAKES YOUR PAIN FEEL BETTER? _____

DESCRIBE HOW THIS PROBLEM IS AFFECTING YOUR LIFESTYLE, YOUR ACTIVITIES OF DAILY LIVING OR YOUR ABILITY TO WORK:

_____

_____

DR. NOTES: _____

_____

PATIENT NAME _____

PROBLEM#2: _____

WHEN DID THIS PROBLEM START? _____

HOW OFTEN DO YOU EXPERIENCE THIS PROBLEM?_____

HAVE YOU HAD THIS PROBLEM IN THE PAST? _____ IF YES, WHEN?_____

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION AND BY WHOM? _____

_____

WHAT CAUSED THIS PROBLEM; CAR ACCIDENT, WORK INJURY, OTHER TYPE INJURY, AGGRAVATION OR OLD INJURY, ETC?

_____

DESCRIBE WHERE YOU FEEL THE PAIN/PROBLEM_____

DID THIS PROBLEM: ☐ BEGIN SUDDENLY ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

RATE YOUR AVERAGE PAIN LEVEL ON A SCALE FROM 0 TO 10:

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (SERIOUSLY BAD PAIN!)

IS YOUR PROBLEM: ☐ STAYING THE SAME ☐ WORSENING ☐ IMPROVING

WHAT MAKES YOUR PAIN FEEL WORSE? _____

WHAT MAKES YOUR PAIN FEEL BETTER? _____

DESCRIBE HOW THIS PROBLEM IS AFFECTING YOUR LIFESTYLE, YOUR ACTIVITIES OF DAILY LIVING OR YOUR ABILITY TO WORK:

_____

_____

DR. NOTES: _____

_____

PATIENT NAME _____

PROBLEM#3: _____

WHEN DID THIS PROBLEM START? _____

HOW OFTEN DO YOU EXPERIENCE THIS PROBLEM?_____

HAVE YOU HAD THIS PROBLEM IN THE PAST? _____ IF YES, WHEN?_____

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION AND BY WHOM? _____

_____

WHAT CAUSED THIS PROBLEM; CAR ACCIDENT, WORK INJURY, OTHER TYPE INJURY, AGGRAVATION OR OLD INJURY, ETC?

_____

DESCRIBE WHERE YOU FEEL THE PAIN/PROBLEM_____

DID THIS PROBLEM: ☐ BEGIN SUDDENLY ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

RATE YOUR AVERAGE PAIN LEVEL ON A SCALE FROM 0 TO 10:

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (SERIOUSLY BAD PAIN!)

IS YOUR PROBLEM: ☐ STAYING THE SAME ☐ WORSENING ☐ IMPROVING

WHAT MAKES YOUR PAIN FEEL WORSE? _____

WHAT MAKES YOUR PAIN FEEL BETTER? _____

DESCRIBE HOW THIS PROBLEM IS AFFECTING YOUR LIFESTYLE, YOUR ACTIVITIES OF DAILY LIVING OR YOUR ABILITY TO WORK:

_____

_____

DR. NOTES: _____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a Notice of Information Practices that provided a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health information for directory purposes
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Patient Signature_____ Date_____

Informed Consent for Chiropractic Treatment

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment.

I understand that there are risks associated with receiving chiropractic treatment, including, but not limited to:

- Broken Bones
- Dislocations
- Sprains/strains
- Worsening/aggravation of spinal/presenting conditions
- No improvements of condition/symptoms

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a neck adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movements), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and that an undesirable result does not necessarily indicate an error in judgment, negligence, or the rendering of inappropriate treatment. I also attest that no guarantees or promises have been made to me concerning the results to be expected from the treatment.

I have had the opportunity to discuss with the attending chiropractor, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, and alternatives to my chiropractic treatment, including no treatment at all.

I hereby request and consent to the chiropractic treatment and therapies as necessitated by the attending chiropractor. I understand that during the course of care, my care will involve decision making based upon facts known to the attending chiropractor at that time. Therefore, I wish to rely on the attending Doctor of Chiropractic, to utilize his judgment during the course of care that he believes at the time, based upon facts known, to be in my best interest.

Printed Name of Patient_____

Patient Signature _____Date:_____

Legal Guardian Signature _____

Doctor's Comments: _____

_____

Payment/Authorization/Consent Form

I understand and agree that I am ultimately responsible for payment of all fees incurred by me or my dependent(s) at this office. Should collection of past due amounts become necessary, I will become responsible for all incurred late charges and/or attorney fees associated with this past due amount. I hereby authorize this office to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance submissions. Please understand at times, your insurance company may forward payment of our fees to your residence. Please contact us if you do get insurance money sent to you so that we can acquire these monies and determine what charges the payment is for.

Patient Signature_____ Date_____

Payment Authorization:
I, hereby, irrevocably authorize and direct my attorney, as my representative, to allow and/or pay any and all auto or health insurance reimbursements that my policies allow, as related to my fees incurred at LifeStyle Chiropractic, without interruption, delay, and/or reduction, to LifeStyle Chiropractic. This authorization/notification/direction for you, my attorney, will stay in force as long as I remain a patient with LifeStyle Chiropractic and/or have monies due them. This letter of direction and authorization cannot be modified or revoked without the expressed written consent of LifeStyle Chiropractic.

Patient Signature _____ Date _____

Records Release Authorization:
I authorize the office to release my personal or dependants medical records, or any pertinent information regarding my care to my insurance company, adjuster, attorney, hospital, or physician upon request and with a signed authorization release. I authorize any medical facility to relinquish medical records, diagnostic reports or other pertinent information regarding mine or my dependants care to this office.

Patient Signature_____Date_____

Non-Pregnancy Verification:
I understand that x-rays can be hazardous to an unborn child. I hereby notify all concerned, that I neither suspect or nor know positively at this time that I may be or that I am pregnant.

Patient Signature_____Date_____

X-ray Consent:
I understand that the purpose of x-rays is to help analyze the spine and to assist in determining the appropriateness of chiropractic treatment. I consent to the spinal x-rays determined to be medically necessary by the attending chiropractor.

Patient Signature_____Date_____

Consent To Treatment of A Minor:

I hereby authorize the attending chiropractor to administer treatment deemed necessary to my minor dependant.

Minor's Full Name _____
Parent/Legal Guardian Signature _____Date_____