Whom may we thank for referring you to this office → _____

APPLICATION FOR CARE AT LAKEWOODS CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date:_____-_____-_____ Age: _____ ☐ Male ☐ Female

Address:_____City:_____State:_____Zip: _____

E-mail Address:_____Home Phone:_____Mobile Phone:_____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Insurance Carrier:_____

Social Security #:_____Health Card ID #: _____

Employer:_____Occupation: _____

Spouse's Name_____Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact:_____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily:_____Third:_____Fourth: _____
Is your problem the result of ANY type of accident? ☐ Yes, ☐ No ☐ Auto ☐ Work Comp ☐ Other _____

Primary Complaint_____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaint by ***circling the number***:
Primary complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____

Describe the pain _____

When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when:_____by whom? _____

What relieves your symptoms? _____

What makes them feel worse? _____

Describe the pain _____

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times?_____ When was the last episode?_____How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment:_____, and who provided it:_____**How long ago?**_____What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____

(Additional complaints continued next page)

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Secondary Complaint_____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaint by c***ircling the number***:
Secondary complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____

Describe the pain _____

When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?_____

What relieves your symptoms? _____

What makes them feel worse? _____

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times?_____ When was the last episode?_____How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment:_____, and who provided it:_____**How long ago?**_____What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____

_____

PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for *N**ever** have had***:**

___ Broken Bone ___Dislocations _____Tumors _____Rheumatoid Arthritis ___Fracture ___Disability_____Cancer
___ Heart Attack ___Osteo Arthritis_____Diabetes_____Cerebral Vascular ___Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

_____ _____ / _____ / _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ / _____ / _____
Doctor's Signature **Date Form Reviewed**

Patient's Name: _____

Patient's Name: _____

Lakewoods Chiropractic

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___Headache	___Pregnant (Now)	___Dizziness	___Prostate Problems	___Ulcers
___Neck Pain	___Frequent Colds/Flu	___Loss of Balance	___Impotence/Sexual Dysfun.	___Heartburn
___Jaw Pain, TMJ	___Convulsions/Epilepsy	___Fainting	___Digestive Problems	___Heart Problem
___Shoulder Pain	___Tremors	___Double Vision	___Colon Trouble	___High Blood Pressure
___Upper Back Pain	___Chest Pain	___Blurred Vision	___Diarrhea/Constipation	___Low Blood Pressure
___Mid Back Pain	___Pain w/Cough/Sneeze	___Ringing in Ears	___Menopausal Problems	___Asthma
___Low Back Pain	___Foot or Knee Problems	___Hearing Loss	___Menstrual Problem	___Difficulty Breathing
___Hip Pain	___Sinus/Drainage Problem	___Depression	___PMS	___Lung Problems
___Back Curvature	___Swollen/Painful Joints	___Irritable	___Bed Wetting	___Kidney Trouble
___Scoliosis	___Skin Problems	___Mood Changes	___Learning Disability	___Gall Bladder Trouble
___Numb/Tingling arms, hands, fingers		___ADD/ADHD	___Eating Disorder	___Liver Trouble
___Numb/Tingling legs, feet, toes		___Allergies	___Trouble Sleeping	___Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take: _____

_____

_____

List any supplements you take regularly:_____

_____

_____

Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Other:_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

_____ _____ / _____ / _____

Patient or Authorized Person's Signature **Date Completed**

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____

Please describe the manner of the injury _____

Was treatment received? Please describe _____

Does your job require you remain in long term stressful postures?_____

(*I.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? _____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field_____

Trauma as a child! I.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident_____

Work around the house – lifting, bending, woke up with stiff neck, "back went out"

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

Patient's Name: _____

FAMILY HEALTH HISTORY

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation "C "under his or her column. The designation "P" should be used to indicate a past problem. Leave blank spaces for those that do not apply.

Condition	Father Age___	Mother Age___	Spouse Age___	Brother(s) Age___	Age___	Sister(s) Age___	Age___	Children Age__	Age___
Arthritis									
Asthma									
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									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

LAKEWOODS CHIROPRACTIC - NOTICE OF PRIVACY PRACTICE

Lakewoods Chiropractic is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information (PHI). In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the bottom of this page and return it to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes- to obtain payment from your insurance company or any available collateral source.
4. For workers compensation purposes-to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For public health and safety- in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement- to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons-discussions with coroners and medical examiners in the event of a patient's death.
10. Phone calls, texts, emails and appointment reminders - we may contact your home/mobile phone and leave messages regarding a missed appointment or to apprize you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of any known disclosure violations.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to - If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance (72 hours). X-rays are original records and you are therefore not allowed to keep them. You may request a copy (Digital CD) of your X-Rays or check them out for up to 30-days.
6. To request amendments to information, however like restrictions we are not required to agree to them.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call Cary Gerard at 651-464-0800. If unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

Lakewoods Chiropractic 255
Hwy 97 Suite 2A Forest
Lake, MN 55025

Note: This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I have reviewed the Lakewoods Chiropractic Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I understand that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____(Patient or Authorized Person's Signature) Date_____

_____(Witness Signature) Date_____

Lakewoods Chiropractic

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Lakewoods Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

I hereby authorize payment to be made directly to Lakewoods Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Lakewoods Chiropractic for any and all services I receive at this office.

_____ _____/_____/_____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____ -____ -____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____/_____/_____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

MALES ONLY → By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the risks associated with exposure to x-rays. I have conveyed my understanding, and after careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____/_____/_____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date