WELCOME!

To ensure your visit to Lakeview Chiropractic is a pleasant one, here is what you can expect during the next 45-60 minutes.

Personal Information	Complete this brief questionnaire and health history form to help us get to know you. The Doctor will use this information to help formulate the recommendations for your care.
Consultation	You will meet the Doctor; the Doctor will review your history and determine if yours is a Chiropractic case.
Examination	Thorough physical, orthopedic, neurologic and chiropractic tests will be performed to determine the cause(s) of your presenting complaint.
Imaging	Necessary views may be taken to visualize the location of any problems, neurologic interferences, reveal any pathology and make your chiropractic care more precise
Correlation	Before proper care can be rendered, the Doctor will study your examination findings. Later you will see your x-rays, review your findings and receive specific care and recommendations from your Doctor.

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the Doctor during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

PLEASE PRINT Date____________________

Name ____ Sex (M) _________ (F) _________

Address ____

City___________________________________ State _______________ Zip _______________

Home Phone ______________________ Cell ____________________ Text reminders? Yes or No

Email address: ____

Age____ Date of Birth ________ Status: Married ____ Single _____ Widowed ______ Divorced ______

Occupation _______________________________ Employer _______________________________

Person Responsible for this account ___________________________ Health Plan _______________

Subscriber's Name ____________________________________ Subscriber's DOB _______________

Subscriber's Employer ____

Whom can we thank for sending you to our office? ____

Current complaints and symptoms- please be as specific as you can

____

____

How do you believe your problem began?

____

____

When did you first notice this problem/pain? ____________________

Have you lost any work? ____________________ Date you last worked ____________________

Have you ever had this condition before (or similar condition)? ____________ When? ____________

What positions or activities aggravate your condition? ____________________

____

What positions or activities relieve your condition? ____________________

____

Is condition worse during certain times of the day? ____________________

Have you had chiropractic care before? ____________ For what condition? ____________________

Were the results satisfactory? Why or why not?

____

____

Have you ever been in any significant accidents or suffered serious injury (even as a child)?

____

Are you presently taking any medications (OTC included) ____________ If yes, please list ____________

____

____

____

What operation(s) have you had? ____________________ Year ____________
(If Any)

____________________ Year ____________

____________________ Year ____________

Give dates you have had any of the following (if exact date is unknown, give approximate date)

Blood tests ____________ Urinalysis ____________ MRI ____________ CT scan ____________

Ultrasound ____________ Radiation ____________ X-Ray ____________ Other ____________

Date of last menstrual period ____________ Do you have any reason to believe you may be pregnant? ______

Do you take vitamins? If yes, please list

____

____

Do you exercise? If yes, describe

___

Rate your overall health: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Rate your overall diet: 1 2 3 4 5 6 7 8 9 10

Rate your overall stress: 1 2 3 4 5 6 7 8 9 10

Habits: (please check)

Cigarettes ___ Quantity ___ Coffee ___ Quantity ___

Alcohol ___ Quantity ___ Tea ___ Quantity ___

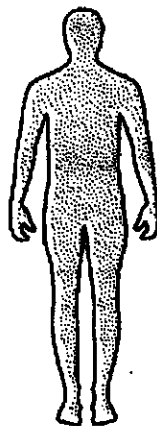
Have you lost or gained weight in the past year?

___

PAIN CHART

Please mark areas and type of pain on the drawings
Using the codes listed below.

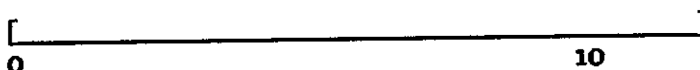
N = Numbness
P = Pins & Needles
B = Burning
A = Aching
S = Stabbing



VISUAL ANALOG SCALE

Use the line to rate the intensity of your pain today.

0 = No pain 10 = Most Intense ever felt



Have you had, or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had this condition in the past.

	Now	Past		Now	Past
Headaches	____	____	Frequency/loss of balance	____	____
Neck pain	____	____	Fainting	____	____
Stiff neck	____	____	Loss of smell	____	____
Sleeping	____	____	Loss of taste	____	____
Back	____	____	Pain/Diarrhea	____	____
Nervousness	____	____	Cold feet	____	____
Tension	____	____	Cold Hands	____	____
Irritability	____	____	Arthritis	____	____
Chest pains	____	____	Muscle spasms	____	____
Dizziness	____	____	Frequent Colds	____	____
Shoulder/Neck/Arm	____	____	Stomach upset	____	____
Pins & Needles in Arms	____	____	Constipation	____	____
Pins & Needles in Legs	____	____	Cold sweats	____	____
Numbness in Fingers	____	____	Fever	____	____
Numbness in Toes	____	____	Sinus problems	____	____
High blood pressure	____	____	Diabetes	____	____
Difficulty urinating	____	____	Hemorrhoids	____	____
Allergies	____	____	Leg cramps	____	____
Weakness in Arms	____	____	Colitis	____	____
Weakness in legs	____	____	Gall bladder	____	____
Shortness of breath	____	____	Indigestion	____	____
Fatigue	____	____	Belching	____	____
Depression	____	____	Vomiting	____	____
Light bothers eyes	____	____	Shoulder pain	____	____
Loss of memory	____	____	Swelling joints	____	____
Ears ring	____	____	Knee Pain	____	____
Face flushed	____	____	Hay fever	____	____
Buzzing in Ears	____	____	Menstrual difficulties	____	____

The major health problems of your immediate family will assist us in understanding your health patterns. Report any diseases, sicknesses

Relation	Health problem(s)	Age and cause of death

Lakeview Chiropractic Insurance Agreement

We would like to notify you that many changes are being made in insurance policies. Therefore, we ask that you read and sign the following.

Because the rules of coverage are constantly and rapidly changing, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible-they all vary considerably. Occasionally, an insurance company gives us outdated information from their computers and we are informed later that your coverage changed. For individuals with network-type policies, you may find that a physician referral is necessary or you must use a doctor within your insurance company network.

It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. **Please remember, your insurance policy is between you and your insurance company, not between your doctor and your insurance company.**

Please call your insurance company and learn about your coverage; it may save you time and money. Feel free to ask us for assistance in finding the phone numbers or addresses of your insurance company.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize Lakeview Chiropractic, Inc. to release any medical information required to bill my insurance company. I understand that I am financially responsible to Lakeview Chiropractic, Inc. for charges not covered by my insurance.

I have read and understand the above information and assignment of benefits.

Signature ______________________________ Date ______________

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, ______________________________________, have received a copy of Lakeview Chiropractic's Notice of Privacy Practices. I understand that 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 among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

I further understand that Lakeview Chiropractic operates on a semi-private office setting; however, for confidential purposes, private rooms with doors are available upon my request including, an exam room, x-ray room, two adjustment rooms, and a personal consultation room.

____
Patient Name (Print)

______________________________ ______________________________
Signature Date

The Following person(s) may receive disclosure of protected health information about me:

Name ____

____

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)**

____

____

______________________________ ______________________________
Staff signature **Date**

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LAKEVIEW CHIROPRACTIC
2100 Water Street
Port Huron, MI 48060
810-982-2700

It is the policy of Lakeview Chiropractic to charge a $25.00 fee for missing a scheduled massage appointment without a 24 hour cancellation notice. Please understand that this is in effect to cover expenses for the massage therapists who make themselves available for these appointments. If a patient does not show for his/her appointment, the therapist does not get reimbursed for these expenses. Exceptions will be made for emergencies and illness, but please call as soon as possible.

______________________________ Patient's Signature

__________ Date