CRAVEN CHIROPRACTIC CLINIC PATIENT INFORMATION

Name: _____Date:_____CASE #_____

Address: _____Date of Birth:_____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

What number do you prefer we reach you at? ☐ Home ☐ Work ☐ Cell

Email Address: _____ Occupation: _____

Marital Status: __Married __Single Spouse's Name:_____

HOW WERE YOU REFERRED TO US:____ GOOGLE SEARCH____ WEBSITE____ NEWSPAPER AD___ LOCATION

___INSURANCE COMPANY ___ REFERRED BY (Patients name:)_____

Name of Insurance Company: _____

Policy #: _____ Group #_____

Policy Holders Name: _____ DOB:_____

Social Security # of policy holder: _____-_____-_____

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen

☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other: _____

List any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist/Hand

☐ Other: _____

List **ALL Past Medical History** conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression

☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain

☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure

☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain

☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's

☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain

☐ Stroke/Heart Attack ☐ Other: _____

List all the **NAME OF ALL MEDICATIONS AND THE REASON** you are currently taking: (Example: Ibuprofen – Pain)

1_____ 2_____

3_____ 4_____

5_____ 6_____

Are you allergic to any medications: ☐ No ☐Yes _____

PAGE 2 PATIENT NAME:_____ DATE_____

Do you take any nutritional supplements? If so please list: _____

_____

List your Family History:

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack

Please list all family members who had/has any of the problems above: Example: Grandmother – High blood pressure

_____ _____

_____ _____

_____ _____

Have you had any auto or other accidents in the past? □ No □Yes When did this occur? _____

Describe: _____

What was date and reason for last physical examination?: _____

Do you smoke? □ No □Yes –How many per day? _____ If no were you a former smoker? □ No □Yes

Do you drink alcohol? □ No □Yes - how many per day/week? _____

Do you drink caffeine? □ No □Yes - how much per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

Have you ever had chiropractic care? Yes □ No□ Where?_____

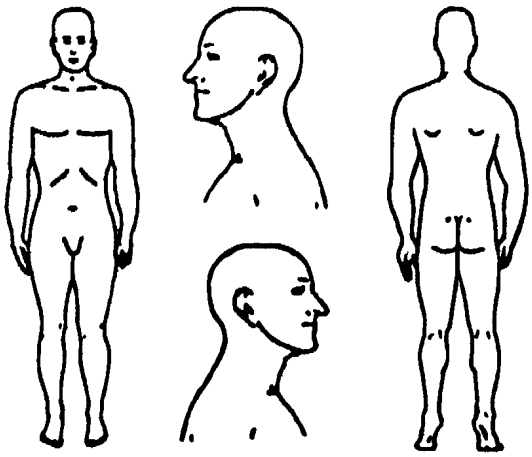
Reason for care ? _____ When was your last visit?_____

What was done on your visits and how did you respond? _____

_____

Were X-Rays taken? □ Yes___ No___

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reasons for consulting the office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity

What concerns you the most?_____

_____

_____

PAGE 3 PATIENT NAME:_____DATE:_____

What is your **PRIMARY** complaint? _____

Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your **SECOND** complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

PAGE 4 PATIENT NAME:_____ DATE:_____

What is your **third** complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your **fourth** complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Are there any other complaints or issues we need to discuss at this time?

_____

_____

Signature_____Date_____

CRAVEN CHIROPRACTIC

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to Craven Chiropractic, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Craven Chiropractic or their attorneys in order to claim such benefits.

I also assign and/or convey Craven Chiropractic, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort-feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). Craven Chiropractic or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Craven Chiropractic, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

We will submit and appeal your claims to the insurance you provided. In the event your insurance continues to deny your claim.

This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature: _____ date: _____

Name: _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Patient Name (please print) Date

_____
Parent, Guardian or Patient's legal representative

_____
Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

LAKES CHIROPRACTIC AND WELLNESS
DOCTOR-PATIENT RELATIONSHIP AND CHIROPRACTIC INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to improve health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent healing ability through the activation of the central nervous system. The success of your chiropractic treatment often depends on underlying physical and spinal conditions. It is important to understand what to expect from your chiropractic health care. Some conditions will heal quickly and some may take more times.

ADJUSTMENTS

The Doctors at Lakes Chiropractic and Wellness mainly use diversified manipulation techniques, which is the most widely utilized form of Chiropractic Manipulative Treatment (CMT). CMT involves highly skilled touch and inherent knowledge to be able to diagnose and treat the spine and extremities. The Doctors of Lakes Chiropractic also utilize many rehabilitative techniques. These include active and passive therapeutic exercises, as well as specialized soft-tissue techniques to decrease pain, increase range of motion, and restore proper biomechanics to the involved joints and musculature.

INFORMED CONSENT FOR CHIROPRACTIC CARE

As a patient, you give the doctors of Lakes Chiropractic and Wellness permission and authority to care for you in accordance with their chiropractic findings. Chiropractic adjustments or other clinical procedures are typically beneficial and seldom cause problems. In rare cases, the patient may experience soreness and mild pain after a treatment. It is extremely rare, but as with any form of health care there are inherent risks which include, but are not limited to the following: fractures, sprain/strains and stroke. It is your responsibility to tell the doctor everything you know about your health conditions which would otherwise not come to the attention of the doctor of chiropractic.

The doctor may advise you to perform or discontinue certain activities that may affect your condition. The patient hereby understands it is their responsibility to monitor their own health and assume all risks related to their behavior and / or decisions to care in this office.

AUTHORIZATION

In certain cases, it may be necessary for the doctor to discuss or send reports to other doctors, attorneys and or insurance carriers. As a patient, you are giving the doctor permission to do so.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy. I understand the following and give my consent.

_____ Date_____

Printed name of patient, parent, guardian or authorized representative

_____ Date_____

Signature name of patient, parent, guardian, or authorized representative