Lenahan CHIROPRACTIC

NEW PATIENT INFORMATION

The purpose of this office is to educate as many families as possible about the spinal condition known as *Vertebral Subluxation*. ***Vertebral Subluxation*** destroys an optimal spine and your ability to have Optimal Health. Your experience with this office will not only be of healing but also of learning the truth about **optimal health and healing.**

Name:	Today's Date:	
Address:		
City/State/Zip:		
Home Phone:	Work Phone:	Cell Phone:
Birth date:	Age:	Social Security #:
Marital Status: M W D S	Email Address:	
Your Employer:		Occupation:
Spouse's Name:		Spouse's Employer:
Children's Names & Ages:		
Your Favorite Hobbies:		
Emergency Contact:	Cell Phone:	Home Phone:
Who may we thank for referring you?		
When did you last see a chiropractor?		Dr.:
Are you here because of a recent auto or work injury?		Date of Accident:
Primary Physician:		
Height:	Weight:	
Ever diagnosed with cancer?	What kind?	
Other illnesses?		
Medicines you take:		Vitamins/Supplements:
Surgeries you've had (circle all that apply; write in others): hysterectomy, appendectomy, gall bladder, tonsils, c- section, cataracts, knee, hip, back		
Who is financially responsible for this bill?		
Method of payment: [ ] Cash	[ ] Check	[ ] Credit Card [ ] Insurance

A. The vast majority of our patients have experienced dozens of impacts that could cause Vertebral Subluxations. Help us discover a few of yours.

1. How many total auto accidents have you been involved in? (Please Circle)
   5+ 3-4 1-2 0 Motorcycle accidents? Yes No

2. Which of the following sports have you been involved in? (Please Circle) football, basketball, soccer, field hockey, gymnastics, horseback riding, martial arts, rollerblading, other:_____

3. Have you ever…(please check) □ fallen down stairs □ slipped on ice or snow
   □ had a stress or strain while working □ sports injury

4. Do you… □ sit more than four hours per day □ drive more than two hours per day

5. Are you a… (please check) □ computer operator □ assembly line worker
   □ construction worker □truck driver □single or working parent (other)_____

B. **Subluxation** is when a bone moves and pushes on a nerve cutting off information to the brain. Subluxations can cause malfunction in any part of the body. Please check health complaints you are currently experiencing:

☐ Low Back Pain	☐Arm/Hand Problem	☐Carpal Tunnel Syndrome	Other
☐ Neck Pain	☐ Leg/Foot Problem	☐Ear Infections	_____
☐ Headaches	☐ Asthma	☐ Frequent Colds/Infections	_____
☐Upper/Mid Back	☐ Allergies	☐Spinal Curvature	_____
☐Shoulder Pain	☐ Sinus Problems	☐ Digestive Problems	_____

What activities would you like to do that your health is impairing you from doing? _____

_____

How would your life change if you had optimal health? _____

_____

What needs to happen in order for you to have optimal health and healing? _____

_____

1. All first visit charges are payable when services are rendered.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes they cannot be released.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Lenahan Chiropractic LLC will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Lenahan Chiropractic LLC will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment.

_____ _____

Patient/Guardian's Signature Date

I have reviewed this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Lenahan Chiropractic LLC for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices. A personal copy can be made available upon my request.

Printed Patient Name _____ Date _____

Signature _____

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____

Lenahan CHIROPRACTIC

837 Upper Main Street, South Amboy, NJ 08879
Phone: (732) 316-4004 || Fax: (732) 316-4005

Office Cancellation Policy

Please understand that our appointment times are scheduled to allow us to take care of each individuals' needs. Since appointment times at Lenahan Chiropractic, LLC are in high demand, we must maintain a No-Show/Cancellation Policy in our office. We value 24 hours' notice from our patients who are unable to keep their scheduled appointment times.

The following cancellation fees are will be in effect immediately:

$25 for Chiropractic appointments
$25 for Massage Therapy appointments
$50 for Acupuncture appointments

Patients will not be charged if a cancellation is made 24 hours before their appointment.

I agree and acknowledge that my signature on this document authorizes the provider to submit for myself, or dependents charges for appointments missed with less than 24 hours' notice. I understand that these charges will be automatically applied to patient accounts.

Patient/Guardian Name: _____

Signature: _____

Date: ____ /____ /_____ Witness: _____

Lenahan CHIROPRACTIC

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Pregnancy Release Form

It is recognized that ionizing radiation can be harmful to a fetus or that the effects of a magnetic field has been undetermined as of yet. It is the policy of Lenahan Chiropractic, LLC, that women who are pregnant or suspect that they are pregnant should not have an exam that utilizes ionizing radiation or magnetic fields unless the referring physician and/or radiologist determine the exam is medically necessary. Lenahan Chiropractic, LLC requires confirmation of pregnancy/non-pregnancy for women of childbearing age prior to performing any radiographic procedure involving ionizing radiation or magnetic field. Childbearing age is considered to be between 10-60 years of age.

This is to certify that to the best of my knowledge, **I am not pregnant** and Dr. Timothy Lenahan has my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. _____ (Patient's Initials)

By signing below, I agree that the above statements are true and hereby release Lenahan Chiropractic, LLC and its providers from any complications that may occur from exposure to radiation or a magnetic field and assume responsibility for my decision to undergo the procedure/exam.

Patient Name: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Lenahan CHIROPRACTIC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The 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 of the spine.

Health: The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations, or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination 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 another health care provider.

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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustment.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)