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

APPLICATION FOR CARE AT Lane Avenue Chiropractic

Today's Date: _____

PATIENT DEMOGRAPHICS

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

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Mobile Phone:_____ Carrier: _____

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Height: _____ Weight: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Number of children and Ages: _____ Is it ok to text your cell: YES / NO

Name & Number of Emergency Contact: _____ _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

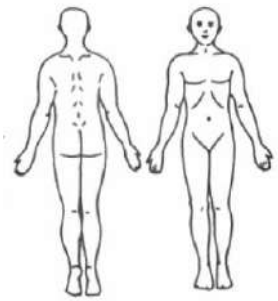
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*****:**

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Date problem(s) begin? _____ 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?_____

***PLEASE MARK: X = Pain N = N**umbness



How Serious is your problem is to you? 0-10: _____

What relieves your symptoms? _____

What makes them feel worse? _____

What activities are you unable to do because of this problem? :

What have you tried to do to relieve/ get rid of this problem? (Ex: physical therapy, exercise, etc.):

Have you had any Cortisone/Corticosteroid injections? Yes No

If yes, when was your last injection? _____

Have you consistently used Systemic Corticosteroids within 2 weeks? Yes No

Have you used NSAIDs (ie. Ibuprofen, Aleve, etc) within the last 2 weeks? Yes No

If yes, when was your last dose? _____

What is your Occupation? _____

How has this pain affected your work? _____

Any history (past or present) of Blood clots? Yes No

Do you take Blood Thinner Medication? Yes No

If yes, name of medication: _____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

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

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 ***Never** have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

Have you ever been diagnosed with:

- ☐ Osteoporosis, or osteopenia
- ☐ Spondylolisthesis
- ☐ Spinal stenosis
- ☐ Spinal infection
- ☐ Spinal tumor
- ☐ Ankylosing spondylitis

By checking the box in this section, I certify that :

- ☐ I am NOT Pregnant
- ☐ I do NOT have a broken vertebrae
- ☐ I do NOT have an artificial disc, or other implants in my spine

List any other medical diagnoses you have and any prior procedures/surgeries you have had:

- ❑ NONE

_____
_____
_____

List any medications you take you take (include prescribed medications, over-the-counter medications, herbal supplements, fish oil, etc.):

- ❑ NONE

_____
_____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom:

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: _____

I hereby authorize payment to be made directly to Lane Avenue 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 Lane Avenue Chiropractic for any and all services I receive at this office.

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

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

Consent for Treatment

The purpose of **spinal manipulation** is to relieve pain and restore joint mobility. This is accomplished by manually applying a controlled force into joints of the spine that have become restricted in normal movement. You may hear and/or feel a "click" or “pop”. Various ancillary procedures such as electrical stimulation, laser, shockwave therapy or KT tape may also be used to facilitate treatment.

Subluxation, Muscle strains, ligament sprains, disc herniation, and soft tissue injuries can be caused by a single traumatic event or through repetitive stress. The injured tissues undergo physical and chemical changes that can cause inflammation, pain, and decreased function. Adjusting restricted joints, performing soft tissue work and/or physical rehabilitation restores mobility, alleviates pain, decreases muscle tightness, and allows for tissue to heal properly.

Laser therapy is a medical treatment that uses specific wavelengths of light to impart energy into injured cells and tissues. This energy is transformed from photon energy to biochemical energy in the cells which can then be used for repair processes in the body. The expected direct outcomes from laser treatment may include reduced inflammation, reduced pain, and repair of tissues. The indirect outcomes may include increased ranges of motion, comfort, and activity levels.

Chiropractic treatment for neuropathy may include supplements, creams, balance exercises, modalities, such as electrical stimulation and modulation, adjustments, and/or non-surgical spinal decompression. It is recommended that you consult with your physician prior to the use of any supplement to discuss potential interactions with your current medications. The proposed treatment is intended to help manage the symptoms of neuropathy and, in some instances, may help relieve some of the symptoms associated with the condition. However, it is important for you to understand that specific results are not guaranteed and there is no promise to cure. Results of the proposed treatment vary by patient and past results do not guarantee any future outcomes.

Extracorporeal Shockwave Therapy is a series of high-energy percussions to the affected area. The shockwave is a physical sound wave “shock”. Shockwave Therapy produces an inflammatory response by which the body responds by increasing metabolic activity around the time which stimulates and accelerates the healing process by promoting the remodeling of collagen tissues. Shockwave therapy has also been shown to break up scar tissue and/or calcifications. There may or may not be immediate pain, but some discomfort may be experienced 2-4 hours after the treatment. In some cases, it can last up to 48 hours and in very rare cases, the pain lasted up to 5 days. Some bruising and swelling can occur.

Non surgical spinal decompression therapy creates a negative pressure within the disc itself to help rehydrate the disc and allow an influx of water and nutrients to help heal the herniated or degenerated disc. You will be harnessed in with 2 separate harnesses and your spine will be gently lengthened to decompress herniated or bulging discs or re-hydrate degenerated discs. This motion opens the space between the vertebrae providing room for the bulging or herniated disc to be drawn back to its central position. _The complications listed are considered rare. The most common risk is a dull, achy soreness like having just worked out for the first time in a long time. This is usually due to stretching of tight muscles that haven’t been stretched in this way. This will typically go away within the first week or two of treatments. We will warm the tissues up before treatment and will decompress your spine more conservative at first to prevent as much soreness as we can. It is recommended that you ice for 20 minutes up to 3 times daily for the first week to decrease pain and soreness.

As with any healthcare procedure, complications may occur following a chiropractic adjustment or other therapeutic activity. The most common side effects of chiropractic care are stiffness, soreness, or headache after the first few treatments. Redness, skin irritation, bruising, and soreness are also possible with ancillary therapies. Serious complications are very rare, but may include fracture, muscular strain, ligamentous sprain, dislocation, and injury to intervertebral discs, nerves or spinal cord. The event of a cerebrovascular injury or stroke even though very unlikely could occur upon severe injury to arteries of the neck. The risk of cerebrovascular injury or stroke is 1:20 million and the evidence for causation due to chiropractic care is very lacking.

Initial: _____

Other treatment options may include: Medical care with prescription medications such as anti-inflammatory drugs, muscle relaxers, or opioids as well as surgery. Self-managed care with the use of over-the-counter medication, rest, and/or surgery if deemed appropriate. There are material risks inherent in each of these options, including but not limited to medication dependence, side effects of medication, improper self-dosages, and surgical risks, including complications from either the procedure or anesthesia. The use of other conservative care providers such as Massage therapy, Physical Therapy, Occupational therapy, or Acupuncture could also help resolve your condition.

Further delay of treatment allows for the advanced formation of adhesions, scar tissue, and degeneration that inhibit range of motion and elongate chronic pain cycles. Delaying treatment can make the resolution of your condition more difficult and increase the time it may take to resolve by up to one and a half times.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

I have read, or have had read to me, and understand this informed consent, including the nature of the proposed treatment and material risks. I have discussed the proposed treatment and risks with my doctor and have had all of my questions answered to my satisfaction. By signing below, I acknowledge that I have weighed the risks involved with the proposed treatment and have decided it is in my best interest to undergo the proposed treatment. Further, by signing below, I consent to receive the proposed treatment and acknowledge that no guarantee can be given as to the results or success of my individual treatment.

_____

Patient Printed Name

_____ _____

Signature of Patient or Authorized Representative **Date**

_____ _____

Signature of Staff **Date**

The patient had the following questions and was supplied the following answers:

_____

It is my clinical opinion this patient is oriented to time and place: Yes No

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*

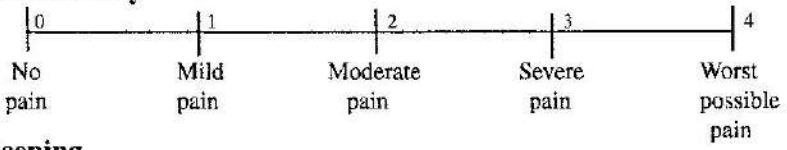
Patient or Authorized person's Signature Date

Functional Rating Index

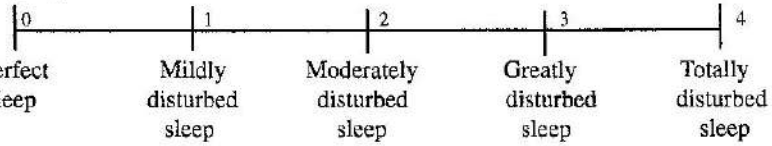
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

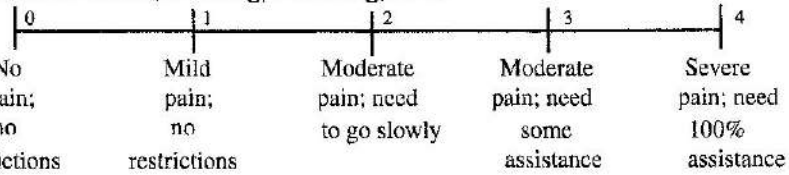
1. Pain Intensity



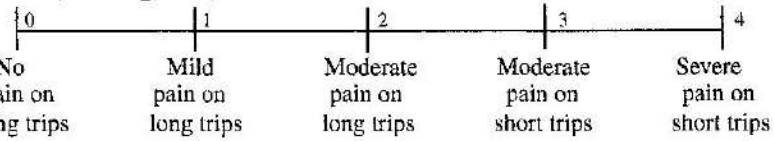
2. Sleeping



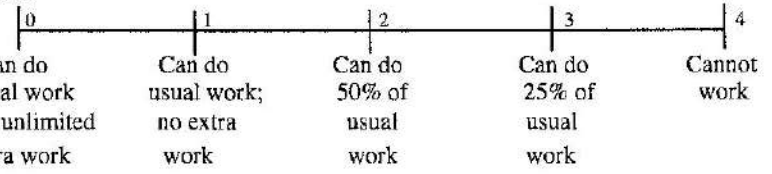
3. Personal Care (washing, dressing, etc.)



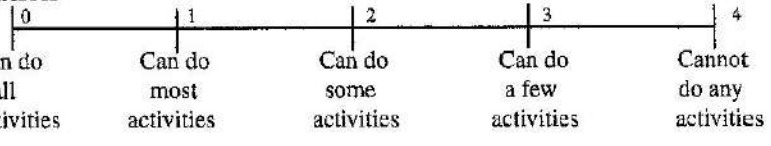
4. Travel (driving, etc.)



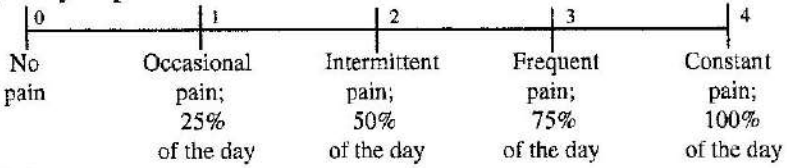
5. Work



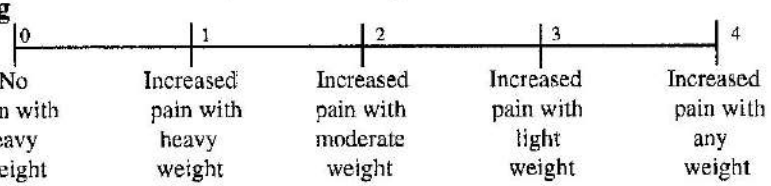
6. Recreation



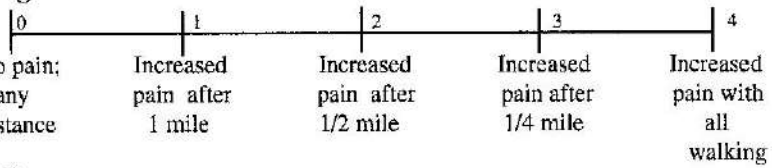
7. Frequency of pain



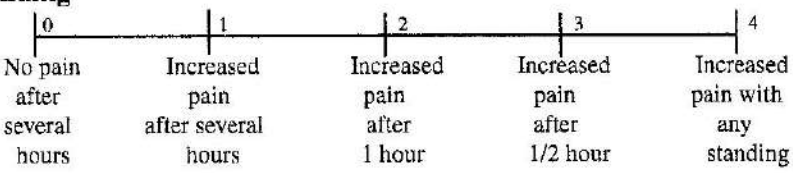
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

Please check mark if you have previously or presently experienced.

___ 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 Disabilty	___ 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:_____

_____

_____

Lane Avenue Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. 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. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

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 other 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 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 –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. 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 disclosures
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, although we are not required to comply. 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
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Lane Avenue Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Lane Avenue Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware 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's Name	DOB	HR#

_____	_____
Patient signature	Date

_____	_____
Witness	Date