Life Family Chiropractic

3769 Attucks Dr. Powell, OH 43065
(614) 760-5433 (p) ~ (614) 760-5434 (f)

Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____Age:_____ Marital Status: M S W D # of Children:_____

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: Ins. Phone #: _____

ID#: _____ Group #: _____

_____ Policy Holder DOB: _____

Name of Policy Holder: _____ _____

Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider **Y / N**)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who & When? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

Are or were you a smoker? **Y / N** If yes, for how long?_____ When did you quit?_____

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

Do you have a Family History of:
Mother's Side: Cancer____ Type:_____ Diabetes: Type 1____ Type 2____ Stroke ____ Cardiovascular____ Other_____
Father's Side: Cancer _____ Type:_____ Diabetes: Type 1_____ Type 2____ Stroke ____ Cardiovascular____ Other_____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Life Family Chiropractic Center** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care
including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured / Guardian Date

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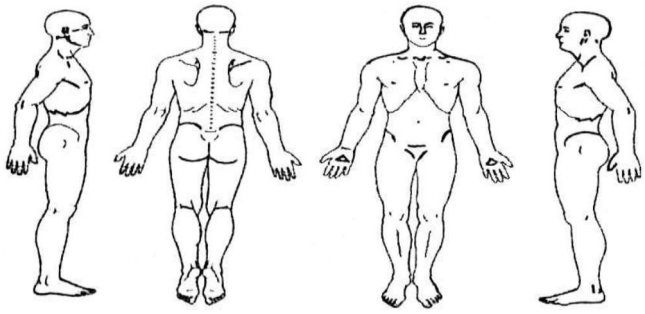
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____Is it due to ____Work____Auto
7. Have you experienced these before? _____
8. Do your symptoms radiate? ____Yes ____ No If yes, from _____to_____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:
    Coughing - Sneezing - Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting – Sleeping - Driving
11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____By Whom? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other musculoskeletal problems? ____No ____Yes …Neurological problems? ——No ____ Yes

_____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

Life Family Chiropractic
Dr. Richard M Shepherd, *D.C.*
3769 Attucks Drive
Powell, OH 43065
Phone: 614-760-5433
Fax 614-760-5434

Informed Consent

The doctor will use hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as a "Spinal Manipulation" or "Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains, and dislocations, Bernard-Horner's Syndrome (also known as Oculosympathetic Palsy), costovertebral strains and separations. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

The doctors are aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to taking a detailed clinical history and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should let us know when we take your clinical history.

Signature _____Date _____

IMPORTANT NOTIVE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Your privacy is important to us. We create information about you so we may provide you with quality care. We are committed to protecting this information. The Notice of Privacy Practices describes your rights with regard to your health information, as well as how we may use your health information, and how we must protect the confidentiality of your health information. This is the summary of the more detailed information contained in our Notice of Privacy Practices.

Your rights include:

- A right to inspect and copy your medical information
- A right to amend your health information
- A right to request restrictions on what information we use or how we disclose your health information
- A right to receive an accounting of certain disclosures we have made of your health information
- A right to receive a paper copy of your Privacy Practices

These rights do have special restrictions, so it is important that you read the full Notice.

We may use your health information and/or records to:

- Plan for your care
- Help your health care providers communicate and work together to care for you
- Submit bills to pay for your care
- Help health care payers make sure services were actually provided
- Help improve the quality of health care. For example, after your visit we may contact you to see how you are doing and find out how you felt about our services.
- Disclose information to certain officials or organizations where we may, or required to do so by law.

Every person who may access your information is bound by our confidentiality requirements, as outlined in our Notice of Privacy Practices.

I give permission to Life Family Chiropractic to use my address, phone number, e-mail,, and clinical records to contact me with birthday cards, holiday related cards, and information about treatment alternatives or other related information.

I give Life Family Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other people in the office may over hear or see, on computer monitors, some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

We encourage you to carefully read the Notice, and ask to speak with the office manager if you need more information. I have received the Notice of Privacy for Life Family Chiropractic.

Signature: _____ Date:_____

Documentation of Attempt: