Office Policy

Welcome to Lake Pointe Chiropractic and Wellness.
Please review the Practice Information and Policies below.

Payment
Payment is due at the time of service. LPCW accepts cash, checks (made payable to LPCW), Visa, and MasterCard. Payment plans are available.

Insurance
Insurance benefits are not a guarantee of payment by your insurance company. We will submit chiropractic claims for you when warranted. Insurance plans do not cover nutritional consultations, wellness services, supplements, herbs, and other products. Payment for these items is your responsibility and due at the time of service/purchase.

It is your responsibility to notify LPCW immediately if your insurance coverage changes or if you are involved in an automobile or worker's compensation accident.

Cancellation Policy
LPCW understands that from time to time there may be conflicts with your schedule. We request that you notify us 24 hours prior to your appointment if you need to cancel or change an appointment. You will be responsible in full for the charges of the appointment with less than 24 hours notice.

Perfumes and Fragrances
Please help those clients with compromised immune systems and sensitivities by not wearing perfumes or fragrances to the office.

HIPAA
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.

If you would like a complete copy of this explanation, please initial here: _____

Please sign and print your name and provide the date below to acknowledge that you understand our Notice of Privacy Practices and Office Policies.

Patient Name: _____

Signature: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Today's Date: ____/____/____

Name:_____ **Date of Birth:**_____

Address:_____ **Height:**_____
_____ **Weight:**_____
_____

Cell Phone:_____ **Home Phone:** _____

Emergency Contact:_____
Cell Phone: _____ **Home phone:** _____

Primary Care Physician:_____
Phone #:_____

What health issue(s) bring you to the clinic today?

How long have you had these issue(s)?

What treatment are you currently using for relief of this concern?

Do you have other health concerns?

What medications are you currently taking? Please include nutritional supplements, herbs and over the counter medications.

	Name	**Daily Dosage**
1.		
2.		
3.		
4.		

PLEASE CHECK ALL THAT APPLY

HEAD/EYES

- ☐ vertigo
- ☐ dizziness
- ☐ light headedness
- ☐ inability to concentrate
- ☐ poor memory
- ☐ forgetfulness
- ☐ unclear thinking

- ☐ HEADACHES
  - ☐ mild pain
  - ☐ moderate pain
  - ☐ severe pain

  location_____

  frequency_____

  duration_____

- ☐ dull pain
- ☐ sharp pain
- ☐ accompanying nausea

EYE PROBLEMS

- ☐ red eyes
- ☐ itchy eyes
- ☐ floating spots
- ☐ blurred vision
- ☐ cataracts
- ☐ night blindness
- ☐ near sighted
- ☐ far sighted

- ☐ dry eyes
- ☐ corrective lenses

EAR/NOSE/THROAT

- ☐ earaches
- ☐ ringing in ears
- ☐ poor hearing
- ☐ sinus problems
- ☐ nose bleeds
- ☐ recurrent sore throats
- ☐ allergies
- ☐ susceptible to colds
- ☐ frequent upper respiratory problems
- ☐ dry mouth
- ☐ bleeding gums
- ☐ tooth problems
- ☐ grinding teeth

CHEST/LUNG/HEART

- ☐ palpitations
- ☐ irregular heartbeats
- ☐ murmurs
- ☐ chest pain
  date of last blood pressure check__/__/
  b.p. reading ____/____
- ☐ fainting
- ☐ frequent sighing
- ☐ hot sensation in chest
- ☐ shortness of breath
- ☐ weak voice
- ☐ cough
- ☐ coughing up blood
- ☐ phlegm
- ☐ difficulty breathing

DIGESTION/ELIMINATION

- ☐ nausea
- ☐ flatulence
- ☐ vomiting
- ☐ loose stools
- ☐ watery diarrhea
- ☐ constipation
- ☐ blood in stools
- ☐ abdominal bloating
- ☐ gas
- ☐ reflux
- ☐ belching
- ☐ indigestion
- ☐ strong breath odor
- ☐ hemorrhoids
- ☐ low body weight
- ☐ low appetite
- ☐ gnawing hunger
- ☐ thirst
- ☐ prefer cold beverages
- ☐ prefer hot beverages
- ☐ thirst with no desire to drink
- ☐ other_____

URINATION

- ☐ frequent urination
- ☐ wake to urinate
- ☐ pain when urinating
- ☐ difficulty holding
- ☐ dribbling
- ☐ difficulty emptying
- ☐ blood in urine
- ☐ dark urine
- ☐ pale urine
- ☐ cloudy urine

SLEEP

- ☐ heavy
- ☐ dream disturbed
- ☐ difficulty getting to sleep
- ☐ waking during night
- ☐ not restful
- ☐ wake tired in a.m.

ENERGY

- ☐ general fatigue
- ☐ wake tired
- ☐ tire easily
- ☐ energy drop at (time of day)

  _____

SKIN/HAIR

- ☐ dry skin
- ☐ dry hair
- ☐ dandruff
- ☐ hair loss

PLEASE CHECK ALL THAT APPLY

- ☐ oily skin
- ☐ oily hair
- ☐ acne/pimples
- ☐ open sores
- ☐ rashes
- ☐ itching
- ☐ eczema
- ☐ moles
- ☐ cysts/tumors
- ☐ other_____

MUSCULOSKELETAL

- ☐ neck pain
- ☐ muscle pains
- ☐ knee pain
- ☐ back pain
- ☐ foot/ankle pain
- ☐ hand/wrist pain
- ☐ shoulder pain
- ☐ hip pain
- ☐ muscle weakness
- ☐ swollen joints
- ☐ numbness
- ☐ tremors
- ☐ muscle twitches
- ☐ bruise easily
- ☐ injuries

_____date_____
_____ date_____
_____date_____
other_____

GENERAL

- ☐ weight loss
- ☐ weight gain
- ☐ aversion to cold
- ☐ aversion to heat
- ☐ afternoon sweats
- ☐ night sweats
- ☐ cold limbs
- ☐ numbness/tingling in extremities
- ☐ sudden energy drop time of day_____
- ☐ varicose veins

EMOTIONS

- ☐ irritability
- ☐ angry outbursts
- ☐ depression
- ☐ indecision
- ☐ fearful
- ☐ anxiety
- ☐ easily stressed
- ☐ thoughts of suicide

other_____
_____

CHILDHOOD ILLNESSES

(check the most frequent)

- ☐ colds
- ☐ earaches
- ☐ sore throats
- ☐ digestive problems
- ☐ headaches

SIGNIFICANT ILLNESSES

- ☐ asthma
- ☐ cancer
- ☐ diabetes
- ☐ heart disease
- ☐ bleeding disorder
- ☐ pacemaker
- ☐ emphysema
- ☐ pneumonia
- ☐ seizures
- ☐ other

_____
_____

COMMUNICABLE DISEASES

- ☐ hepatitis
- ☐ HIV/AIDS
- ☐ TB
- ☐ herpes
- ☐ chlamydia
- ☐ syphilis
- ☐ gonorrhea
- ☐ other STD's

_____
_____

ADDICTIONS

- ☐ tobacco
- ☐ alcohol
- ☐ other

_____
____

SURGERIES (please describe)

_____date_____
_____date_____
_____date_____
_____date_____

MALE CLIENTS

- ☐ burning urination
- ☐ urinary incontinence
- ☐ impotence
- ☐ prostatitis
- ☐ premature ejaculation
- ☐ nocturnal emissions
- ☐ painful/swollen testicles
- ☐ other_____

_____
_____
_____

FEMALE CLIENTS

- ☐ ovarian cysts
- ☐ yeast infections
- ☐ discharge odor
- ☐ excessive discharge
- ☐ vaginal dryness
- ☐ endometriosis
- ☐ infertility
- ☐ menopausal symptoms
- ☐ hysterectomy, date_____

PLEASE CHECK ALL THAT APPLY

____# of pregnancies _____
____# of full term _____
pregnancies _____
____# of children living _____
____# of miscarriages _____
____# of aborted _____
pregnancies _____
□ pregnant now? _____
____ # months _____
_____
MENSTRUAL _____
_____

□ irregular periods
□ regular periods
____ day cycle
____ days of menstruation
□ breast distention
□ bloating
□ water retention
□ clotting
□ cramping before menses
□ cramping with ovulation
□ cramping after menses
□ cramping during menses

Color of menstrual flow
(e.g. pale, scarlet, purple, brown)

_____
_____
_____
_____

Quality of menstrual flow
(e.g. lots of large clots, heavy flow for first 2 days, spotting for three.)

_____
____
_____
____
_____
____

Other pertinent medical information:

Informed Consent

Welcome to Lake Pointe Chiropractic and Wellness. My goal is to provide my patients with the resources they need to maintain their optimal health.

Traditional Chinese Medicine (TCM) and its related therapies can address a wide variety of acute and chronic complaints. All diagnoses at the clinic are made using the TCM medical model. I, Jalashree Pradhan, am TCM-trained with a Masters-level training. Also, I am a state-licensed acupuncturist and Diplomate of the National Certificate Commission for Acupuncture and Oriental medicine.

The therapies you receive for treatment may include acupuncture, electro-stimulation, acupressure, Moxibustion, Tui Na (Chinese bodywork), herbal medicine, dietary therapy and cupping.

With any medical intervention there are inherent risks that you, as a patient, should be aware of before treatment. Some of the side effects of acupuncture may include: local bruising, bleeding, muscle weakness and soreness, brief and generalized fatigue, sensation of heat, cold, tingling or numbness, brief light headedness or even fainting. As with any procedure that involves penetrating the skin, there is also risk of infection. Herbal prescriptions may have side effects including but not limited to gastrointestinal disturbance and allergic reactions.

I believe that my patients should be active participants in their care. Please feel free to ask any questions about your treatment so that you may continue to make informed, responsible decisions regarding your health care. In addition, I encourage all of our patients to discuss their treatment with their primary care physician. Just as the body works as an integral whole, so must the people who help you to care for it.

I understand that it is my responsibility to inform my practitioner if I am pregnant or believe I may be pregnant, if I have a bleeding disorder, or if I have a pacemaker. I understand that there is a 24-hour cancellation policy at Lake Pointe Chiropractic and Wellness and that it is my responsibility to inform the clinic if I am going to miss a scheduled appointment. I understand that all fees are payable at the time that service is received.

I have read the above and agree to the terms of treatment.

Patient Name: (Print) _____

Patient Signature: _____ Date: _____