

Office Policy



Welcome to Lake Pointe Chiropractic and Wellness

Payment

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

Insurance

Insurance benefits are not a guarantee of payment by your insurance company. 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. 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.

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: _____

Nutrition and Supplement Recommendations

I acknowledge that it is my full responsibility to share my nutritional protocol with medical providers related to my health condition and wellbeing. Please Initial here: _____

Please sign and print your name and provide the date below to acknowledge that you understand and agree to the above Office Policy.

Patient Name: _____

Signature: _____ Date: _____

Patient Information



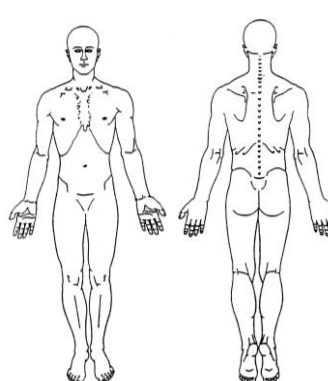
Patient Name: _____ Today's Date: _____
 Date of Birth: _____ Social Sec. #: _____ - _____ - _____
 Sex: Male Female Decline to Specify Ethnicity _____
 Address: _____
 City: _____ State: _____ ZIP _____
 Phone: (Home) _____ (Cell) _____ (Work) _____
 Email: _____ Would you like to be added to our email list? Yes No

Marital Status: Married Widowed Single Divorced Unknown
 Occupation: _____ Employer/School: _____
 Emergency contact: _____ Relationship to patient: _____
 Contact Phone: _____ Alternate Phone: _____
 Referred by: _____

Please describe what brings you in today? _____

When did your symptoms first appear? _____

Rate your pain on a scale from 1 (least) to 10 (severe): **1 2 3 4 5 6 7 8 9 10**

<p>Type of Pain</p> <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Throbbing <input type="checkbox"/> Tingling <input type="checkbox"/> Dull <input type="checkbox"/> Cramps <input type="checkbox"/> Numbness <input type="checkbox"/> Stiffness <input type="checkbox"/> Aching <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____	<p>How often do you have this pain?</p> <input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Weekly	<p>Does it interfere with:</p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Lying Down <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Daily Activities	<p>Mark on the picture where you have symptoms</p> 
<p>What treatment have you already received for your condition?</p> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Medications <input type="checkbox"/> None <input type="checkbox"/> Chiropractic Services <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Other _____ <input type="checkbox"/> Massage <input type="checkbox"/> Surgery _____			

Please describe any injuries or surgeries (e.g. slips/falls, head injuries, broken bones, dislocations, surgeries, auto accidents): _____

Would you like to...

<input type="checkbox"/> Have more energy	<input type="checkbox"/> Have stronger nails/ healthier hair	<input type="checkbox"/> Decrease allergies
<input type="checkbox"/> Lose weight	<input type="checkbox"/> Feel less stressed	<input type="checkbox"/> Decrease drugs/ OTC meds
<input type="checkbox"/> Sleep better	<input type="checkbox"/> Get sick less frequently	<input type="checkbox"/> Improve focus/ memory / mood
<input type="checkbox"/> Improve your complexion	<input type="checkbox"/> Improve your digestion	<input type="checkbox"/> Feel fewer aches and pains

Health History



Date of Last: _____
 Physical Exam _____ Spinal X-Ray _____ Blood Test _____ MRI, CT-Scan, Bone Scan _____

Please check box below to indicate if you have had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Alcoholism/
Chemical
Dependency | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Tumors/ Growths |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mononucleosis | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Decreased Sexual
Drive | <input type="checkbox"/> Pinched Nerve | |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Prostate Problem | |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Prosthesis | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Sexually Transmitted
Disease | |
| | <input type="checkbox"/> Stroke | |
| | <input type="checkbox"/> Suicide Attempt | |

WOMEN

Breast Lump

Endometriosis

Fibroids/ Cyst Ovarian

Hormone Imbalances

Hot Flashes

Menopause

Menstrual Cramps

Vaginal Infections

Birth Control
(Current/ Past)
Type: _____

How long? _____

WOMEN

Are you pregnant? Yes No How many weeks? _____ Estimated due date: _____

Home or Hospital birth: _____ Health Care Providers/Birth Team: _____

Symptoms specific to pregnancy? _____

Concerns related to pregnancy, labor and/or delivery/birth? _____

Number of Pregnancies: _____ Abortions: _____ Miscarriages: _____ Children: _____

Family History

	Living: Y/N	Cause of Death	Age	History of Disease?
Mother				
Father				
Grandparents				
Siblings				

Lifestyle Habits



Exercise <input type="checkbox"/> None <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> 3-4 times per week <input type="checkbox"/> 5-6 times per week <input type="checkbox"/> Daily	Work Activity <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	Eating Habits <input type="checkbox"/> Skip Breakfast <input type="checkbox"/> 1 Meal/ Day <input type="checkbox"/> 2 Meals/ Day <input type="checkbox"/> 3 Meals/ Day <input type="checkbox"/> Graze all day <input type="checkbox"/> Generally eat on the run <input type="checkbox"/> Eat constantly whether hungry or not <input type="checkbox"/> Cravings: <input type="checkbox"/> Bread <input type="checkbox"/> Sugar <input type="checkbox"/> Salt <input type="checkbox"/> Alcohol	Habits <input type="checkbox"/> Water: Glasses/ Day: _____ <input type="checkbox"/> Caffeine Drinks: Type (coffee, soda, tea, etc.) _____ Drinks/ Day: _____ <input type="checkbox"/> Alcohol: Drinks/ Day: _____ <input type="checkbox"/> Smoking: Packs/ Day: _____
Bowel Movements I have bowel movements daily: YES / NO <u>Consistency:</u> <input type="checkbox"/> Diarrhea/ Loose Stools <input type="checkbox"/> Formed <input type="checkbox"/> Constipated			

Sleep Average hours of sleep per night: _____ How long does it take to fall asleep? _____ How many times do you wake up per night? _____ If you wake, up can you fall back asleep? YES / NO Do you wake up tired even when you get enough sleep? YES / NO	Stress Circle the level of stress you experience on the scale of 1-10, 10 being the worst: 1 2 3 4 5 6 7 8 9 10 What do you consider to be the major causes of your stress? (Spouse/family, work, finances): _____
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Allergies
 Please list any allergies (including food allergies): _____
 I am sensitive to: Perfume Tobacco smoke Chemical smells

Please indicate any medications / supplements currently taking:

Medications	How Long?	Condition it's treating	Supplements	Supplement Brand

Estimated monthly medication/ supplement cost? _____
 Are your medications/ supplements working? YES / NO
 How do you know? _____

Commitment to Care

Low Commitment
 Medium Commitment
 High Commitment
 Just Don't Know

Detoxification Questionnaire



Please rate your frequency with the following symptoms:

0 – Never

1 – Seldom

2 – Sometimes

3 – Frequently

HEAD Headaches..... 0 1 2 3
 Faintness.....0 1 2 3
 Dizziness.....0 1 2 3
 TOTAL_____

EYES Swollen, reddened or sticky eyelids.....0 1 2 3
 Bags or dark circles under eyes0 1 2 3
 Watery or itchy eyes.....0 1 2 3
 Blurred or tunnel vision.....0 1 2 3
 TOTAL_____

EARS Itchy ears.....0 1 2 3
 Earaches, ear infections0 1 2 3
 Drainage from ear.....0 1 2 3
 Ringing in ears, hearing loss.....0 1 2 3
 TOTAL_____

NOSE Excessive mucus formation.....0 1 2 3
 Stuffy nose.....0 1 2 3
 Sinus problems.....0 1 2 3
 Hay fever.....0 1 2 3
 Sneezing attacks0 1 2 3
 TOTAL_____

THROAT Chronic coughing..... 0 1 2 3
 Frequent need to clear throat..... 0 1 2 3
 Sore Throat.....0 1 2 3
 Swollen tongue, gums, lips..... 0 1 2 3
 Mouth sores/ sore tongue..... 0 1 2 3
 TOTAL_____

SKIN Acne.....0 1 2 3
 Hives, rashes.....0 1 2 3
 Hair loss.....0 1 2 3
 Flushing, hot flashes.....0 1 2 3
 Excessive sweating.....0 1 2 3
 TOTAL_____

HEART Chest pain..... 0 1 2 3
 Irregular or skipped heartbeat.....0 1 2 3
 Rapid or pounding heartbeat.....0 1 2 3
 TOTAL_____

DIGESTIVE TRACT
 Nausea, vomiting.....0 1 2 3
 Bloating feeling.....0 1 2 3
 Belching, passing gas.....0 1 2 3
 Heartburn.....0 1 2 3
 Stomach pains.....0 1 2 3
 Indigestion.....0 1 2 3
 TOTAL_____

LUNGS Chest congestion.....0 1 2 3
 Asthma, bronchitis.....0 1 2 3
 Shortness of breath.....0 1 2 3
 Difficulty breathing.....0 1 2 3
 TOTAL_____

JOINTS/MUSCLE
 Pain or aches in joints.....0 1 2 3
 Arthritis.....0 1 2 3
 Stiffness or limitation of movement.....0 1 2 3
 Feeling of weakness.....0 1 2 3
 Pain or aches in muscles.....0 1 2 3
 TOTAL_____

WEIGHT
 Binge eating/ drinking.....0 1 2 3
 Craving certain foods.....0 1 2 3
 Excessive weight/ underweight.....0 1 2 3
 Water retention.....0 1 2 3
 Forget to eat.....0 1 2 3
 Compulsive eating.....0 1 2 3
 TOTAL_____

ENERGY
 Fatigue, sluggishness.....0 1 2 3
 Apathy, lethargy.....0 1 2 3
 Hyperactivity.....0 1 2 3
 Restlessness.....0 1 2 3
 TOTAL_____

MIND Poor memory/ forgetful.....0 1 2 3
 Confusion, poor comprehension.....0 1 2 3
 Difficulty in making decisions.....0 1 2 3
 Stuttering or stammering.....0 1 2 3
 Slurred speech.....0 1 2 3
 Learning disabilities.....0 1 2 3
 Poor concentration.....0 1 2 3
 Poor physical coordination.....0 1 2 3
 TOTAL_____

EMOTIONS
 Mood swings.....0 1 2 3
 Anxiety, fear or nervousness.....0 1 2 3
 Anger, irritability, aggressiveness.....0 1 2 3
 Depression.....0 1 2 3
 TOTAL_____

OTHER Frequent illness.....0 1 2 3
 Frequent or urgent urination.....0 1 2 3
 Genital itch or discharge.....0 1 2 3
 _____0 1 2 3
 TOTAL_____

GRAND TOTAL..... TOTAL_____

Stress & Yeast Questionnaires



STRESS ASSESSMENT

- | | | | | |
|---|---|---|---|---|
| 1. Get wound up when I get tired and have trouble calming down | 0 | 1 | 2 | 3 |
| 2. Feel driven, appear energetic but feel "burned out" and exhausted | 0 | 1 | 2 | 3 |
| 3. Feel restless, agitated, anxious and uneasy | 0 | 1 | 2 | 3 |
| 4. Cry easily or laugh inappropriately..... | 0 | 1 | 2 | 3 |
| 5. Find myself worrying about things big and small | 0 | 1 | 2 | 3 |
| 6. Feel like I can't stop worrying even though I want to | 0 | 1 | 2 | 3 |
| TOTAL_____ | | | | |
| 7. Feel impulsive, pent up and ready to explode | 0 | 1 | 2 | 3 |
| 8. Feel aggressive, unyielding, or inflexible when pressed for time | 0 | 1 | 2 | 3 |
| 9. See, hear and smell things that others do not..... | 0 | 1 | 2 | 3 |
| 10. Stay awake replaying the events of the day or planning for tomorrow | 0 | 1 | 2 | 3 |
| 11. Have upsetting thoughts or images enter my mind again and again..... | 0 | 1 | 2 | 3 |
| 12. Have a hard time stopping myself from doing things again and again,
Like checking on things or rearranging objects over and over | 0 | 1 | 2 | 3 |
| 13. Worry a lot about terrible things that could happen if I'm not careful | 0 | 1 | 2 | 3 |
| TOTAL_____ | | | | |
| 14. Have multiple points on my body that when touched are tender or painful..... | 0 | 1 | 2 | 3 |
| 15. Feel a sudden sense of anxiety when I get hungry | 0 | 1 | 2 | 3 |
| 16. Use medications to manage pain..... | 0 | 1 | 2 | 3 |
| 17. Have trouble organizing my thoughts..... | 0 | 1 | 2 | 3 |
| 18. Get easily distracted and lose focus..... | 0 | 1 | 2 | 3 |
| 19. Wake up tired and unrefreshed, even though I seem to get plenty of sleep..... | 0 | 1 | 2 | 3 |
| TOTAL_____ | | | | |
| 20. Feel tired for no apparent reason..... | 0 | 1 | 2 | 3 |
| 21. Experience lingering mild fatigue after exertion or physical activity | 0 | 1 | 2 | 3 |
| 22. Feel cold or chilled – hands, feet, or all over – for no apparent reason | 0 | 1 | 2 | 3 |
| 23. Sweat spontaneously during the day | 0 | 1 | 2 | 3 |
| 24. Feel puffy and retain fluids | 0 | 1 | 2 | 3 |
| 25. Have poor muscle tone | 0 | 1 | 2 | 3 |
| 26. Have trouble losing weight | 0 | 1 | 2 | 3 |
| 27. Have no energy and feel physically weak | 0 | 1 | 2 | 3 |
| 28. Feel dragged down by multiple symptoms such as poor digestion and body aches..... | 0 | 1 | 2 | 3 |
| TOTAL_____ | | | | |

GRAND TOTAL_____

YEAST QUESTIONNAIRE

- | | |
|--|----------|
| 1. Have you taken tetracyclines (Sumycin, Panmycin, Vibramycin, Minocin, etc.) or other antibiotics for acne for one month or longer? | YES / NO |
| 2. Have you ever taken other "broad spectrum" antibiotics for urinary, respiratory, or other infections for two months or longer, or in shorter courses four or more times in a one-year period? | YES / NO |
| 3. Have you ever taken birth control pills or other hormone replacement products? | YES / NO |
| 4. Have you ever been bothered by persistent prostatitis, vaginitis, or other reproductive organ problems? | YES / NO |
| 5. Have you taken Prednisone, Decadron, or other cortisone-type drugs for more than two weeks? | YES / NO |
| 6. Have you had athlete's foot, ring worm, "jock itch", or other chronic fungous infections of the skin or nails? | YES / NO |

Verbal Disclosure Form



Patient Name: _____ Date of Birth: _____

I authorize Lake Pointe Chiropractic & Wellness (LPCW) to verbally discuss the following protected health information about me with the individuals listed below (check all boxes that apply):

- Scheduling/appointment information
- Billing/payment information
- Medical information including symptoms, diagnosis, treatment plans, medications, and recommendations
- Behavioral/mental health information including symptoms, diagnosis, treatment plans, medications, and recommendations
- Chemical dependency information including symptoms, diagnosis, treatment plans, medications, and recommendations
- Lab/test results
- Other (please describe): _____

I authorize LPCW to discuss the information selected above with the following individuals:

Name: _____

Name: _____

Name: _____

Name: _____

I understand that I may revoke this authorization at any time, but that it will not affect any disclosures already made under this authorization prior to revocation. I understand that my revocation of this authorization must be presented in writing to LPCW.

Signature of Patient/ Guardian: _____ Date _____

Functional Physical Pre-test Instructions



Welcome to Lake Pointe's Functional Physical and your next step towards health. To maximize your initial appointment, please follow these instructions:

1. A 12 hour fast is required prior to your test appointment. Do not consume any food or liquid within the 12-hour period prior to your appointment time. You may have small amounts of water during your fast as needed for thirst.
2. Do not brush your teeth or use mint, gum, toothpaste, mouthwash, mouth spray, etc. for 12 hours prior to your test.
3. Do not apply any lotion, body oil, lipstick, or foot deodorant on the morning of your test or wear hosiery.
4. Bring in a sample of your first urine after 4 am on the morning of your test appointment. This sample may be collected in any clean, sealable container you have on hand or you may stop by our office prior to your appointment to pick up a specimen cup.
5. Bring all lab results from previous tests to your test appointment.
6. Complete all new patient paperwork (attached via email and found at lpwellness.com under the Resources tab)
7. Follow the instructions for the Candida Spit test and bring photos to your appointment.

Due to the length of the pre-test fast, you may want to bring a snack and a bottle of water to be consumed after initial testing is finished. You may also bring toothbrush, toothpaste, and other necessary items to your appointment if you so desire.

IMPORTANT: Please note that we strictly enforce a 48-hour cancellation policy for new Functional Physical appointments. Failure to cancel in time will result in a \$200 late cancellation fee

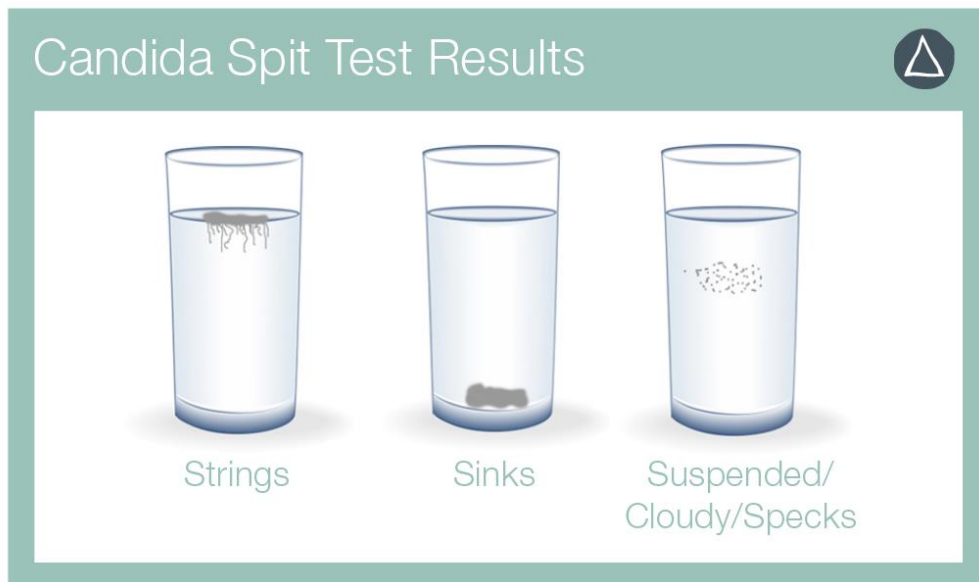
Candida Spit Test



Fill clear glass with water and place on night stand. Upon waking, work up saliva in mouth and spit into glass of water. **It is important nothing touches your mouth/lips prior.** (i.e. do not drink any water, brush your teeth, etc...)

Take 3 pictures similar to the picture noted below.

- ⚠ 1st picture immediately
- ⚠ 2nd picture at 3 minutes
- ⚠ 3rd picture after 15 minutes



Healthy saliva is clear and usually floats on top (may have foam or bubbles) and slowly dissolves into the water without cloudiness or sinking.

Candida saliva will have one or more of the following characteristics which points towards Candida Albicans growth;

More strings and cloudiness there are, and the faster they develop suggest a greater amount of Candida Albicans.

What is Candida?



Candida albicans are a single cell yeast/fungus that is found in practically 100% of the human population. It lives on the mucous membranes of the body, the digestive/intestinal tract, vagina and the skin. In a healthy internal environment, *Candida albicans* will co-exist in the body with no negative side effects. When the body has excess candida, mild to severe symptoms can occur.

Most researchers agree that excess candida is the result of altered/improper balance of gut microflora (dysbiosis). As a result, *Candida albicans* and other "enemies" can over-populate and convert into a fungal form, which produces at least 70 neurotoxins. Dysbiosis can also irritate the gut lining, creating a "leaky gut", and allowing macromolecular absorption of the *Candida albicans*, toxins and potential allergens to enter into our blood stream.

Three main factors that cause/contribute to dysbiosis and candida overgrowth are:

1. The use of antibiotics personally and in your food sources (non-organic meat and dairy).
2. Eating a diet high in processed foods & meats, unhealthy fats, sugar and low in fiber.
3. Use of birth control pills, cortisone, cortisone-like drugs, anti-depressants and immunosuppressant drugs.

Common signs/symptoms include:

Central Nervous System	Gastrointestinal Tract	Genitourinary Tract	Generalized	"Allergic" Symptoms
Headache	Chronic heartburn	Yeast vaginitis	Fatigue	Hay fever
Depression	Gastritis	Irregular menses	Joint pain/stiffness	Sinusitis
Lethargy	Colitis	Cramping	Cold hands/feet	Earaches
Agitation	Distension/bloating	Endometriosis	Increased body hair/acne	Hives/rashes
Hyperirritability	Gas	Cystitis	Numbness/tingling	Asthma
Memory Loss	Constipation	Urethritis	Food cravings	Food Sensitivities
Inability to Concentrate	Diarrhea	Kidney/bladder infections	Loss of libido	Chemical Sensitivities

It is extremely important to identify and implement a program designed to comprehensively approach this problem.