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: _____

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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**

Type of Pain

- ☐ Sharp
- ☐ Throbbing
- ☐ Dull
- ☐ Numbness
- ☐ Aching
- ☐ Burning
- ☐ Tingling
- ☐ Cramps
- ☐ Stiffness
- ☐ Swelling
- ☐ Other _____

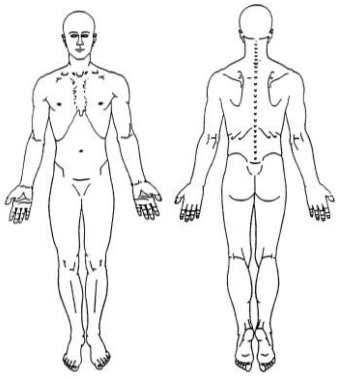
How often do you have this pain?

- ☐ Constant
- ☐ Daily
- ☐ Weekly

Does it interfere with:

- ☐ Sitting
- ☐ Standing
- ☐ Lying Down
- ☐ Sleep
- ☐ Work
- ☐ Daily Activities

Mark on the picture where you have symptoms



What treatment have you already received for your condition?

- ☐ Acupuncture
- ☐ Chiropractic Services
- ☐ Massage
- ☐ Medications
- ☐ Physical Therapy
- ☐ Surgery
- ☐ None
- ☐ Other _____

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

_____ _____ _____

Would you like to…

- ☐ Have more energy
- ☐ Lose weight
- ☐ Sleep better
- ☐ Improve your complexion
- ☐ Have stronger nails/ healthier hair
- ☐ Feel less stressed
- ☐ Get sick less frequently
- ☐ Improve your digestion
- ☐ Decrease allergies
- ☐ Decrease drugs/ OTC meds
- ☐ Improve focus/ memory / mood
- ☐ Feel fewer aches and pains

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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:

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

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				

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Lifestyle Habits

Exercise

- ☐ None
- ☐ 1-2 times per week
- ☐ 3-4 times per week
- ☐ 5-6 times per week
- ☐ Daily

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Bowel Movements

I have bowel movements daily: YES / NO

Consistency:

- ☐ Diarrhea/ Loose Stools
- ☐ Formed
- ☐ Constipated

Eating Habits

- ☐ Skip Breakfast
- ☐ 1 Meal/ Day
- ☐ 2 Meals/ Day
- ☐ 3 Meals/ Day
- ☐ Graze all day
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not
- ☐ Cravings:
  - □ Bread
  - □ Sugar
  - □ Salt
  - □ Alcohol

Habits

- ☐ Water:
  Glasses/ Day: _____
- ☐ Caffeine Drinks:
  Type (coffee, soda, tea, etc.)
  _____
  Drinks/ Day: _____
- ☐ Alcohol:
  Drinks/ Day: _____
- ☐ Smoking:
  Packs/ Day: _____

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):

_____

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

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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 eyes 0 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 infections 0 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 attacks 0 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
Bloated 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_____

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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 _____