Live Natural
Chiropractic Center

Confidential Patient Health Record

PATIENT INFORMATION:

Name: Last _____ First _____ MI ____ Home Phone: (____)_____

Address: _____ City _____ State _____ ZIP _____

Cell Phone: (____)_____ Email Address _____

Social Security # _____ Age _____ Birth Date ___/___/___ Sex _____ Marital Status _____

Name of Spouse_____ Employer _____

Your Employer _____City/State_____Wk Phone (____)_____

Type of Work _____

Name/Relationship of Emergency Contact _____ Phone (____)_____

Who referred you to our office? _____

Do you have insurance you'd like for us to file for you? _____ Name of Insurance _____

Name/Relationship of Insured _____SS#_____DOB ____/____/____

CURRENT HEALTH CONDITION:

What is your primary reason for seeking care at our office? _____
When did it begin? ____/_____/_____
Describe how this began:_____
_____

Is it getting worse? Yes _____ No _____ What is the intensity? None / Mild / Moderate / Severe / Very Severe

Describe the pain (circle all that apply): Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore/ Other: _____
How frequent is the complaint present: Off & On / Constant

Does this complaint radiate/ shoot to any area of your body? No / Yes (Describe)_____

What seems to make it better? Ice / Heat / Rest / Movement / Stretching / Medication/ Other: _____

What seems to make it worse? Sit / Standing / Walking / Lying / Sleeping / Overuse / Other:_____

Does it bother your: Sleep _____ Work _____ Other _____

Have you, received any other treatment for this condition? None / DC / MD / PT / Massage / ER / other:_____

Previous Chiro Care: YES / NO Dr. _____ Other Doctors Seen: _____

Type of treatment: _____ Results _____

Is this condition: Job Related / Auto Related / Home Injury / Fall / Other _____

********* If condition is related to an ***Auto Accident*** or ***Job Injury*** and will be paid for by Worker's Comp or Auto Insurance, ***please*** inform the receptionist **immediately** in order for you to fill out the appropriate paper work!! *********

Please list any medication you are taking now: Blood Pressure / Pain Killers / Muscle Relaxers / Aspirin / Nerve Pills / Insulin / Others _____

Do you suffer from any condition other than that which you are consulting our office? _____

PAST HEALTH HISTORY:

Major Surgery**:** Appendectomy / Tonsillectomy / Gall Bladder / Back Surgery / Other _____

Broken Bones: _____

Major Accidents or Falls: _____

Hospitalizations: (other than above) _____

Below is a list of conditions relative to your overall health status. Although they may seem unrelated to the purpose of your appointment, such conditions may affect your overall diagnosis and treatment. Please consider these conditions carefully and explain the details of any conditions for which you have checked "yes".

MUSCLE/JOINT:
Have you had any problems with the joints of your arms or legs such as pain, numbness, stiffness, joint noise, or arthritis or
bursitis? ☐ Yes ☐ No E**xplain:** _____

RESPIRATORY:
Have you had any problems with shortness of breath, chest or rib pain when breathing, chronic cough, asthma, or bronchitis?
☐ Yes ☐ No **Explain**:_____

SKIN:
Have you had problems with skin dryness, psoriasis, eczema, itching, rash, hives, excessive sweating or "sensitive" skin?
☐ Yes ☐ No **Explain**:_____

NERVOUS:
Have you had pain, numbness, tingling, or other altered sensations of any part of your body, or have you ever suffered from chronic headaches, nervousness, dizziness or psychological disorder?
☐ Yes ☐ No **Explain**:_____

GASTRO-INTESTINAL:
Have you had any disorders of the stomach or bowel such as pain, excessive gas, chronic diarrhea, nausea, vomiting, or reflux?
☐ Yes ☐ No **Explain**:_____

GENITO-URINARY:
Have you ever had trouble with your kidneys or bladder such as chronic infection, pain, frequent urination, difficulty urinating, or discharge?
☐ Yes ☐ No **Explain**:_____

CARDIOVASCULAR:
Have you had problems with blood pressure, chest pain, cholesterol problems, poor circulation, heart rate or rhythm problems? ☐ Yes ☐ No **Explain**:_____

EARS/EYES/NOSE/THROAT:
Have you had problems with earache, sinus pain, sore throat, eye pain or visual disturbance, or discharge of the eyes, ears or nose?
☐ Yes ☐ No **Explain**:_____

Do you suffer from any other conditions not mentioned above? ☐Yes ☐ No
Explain:_____

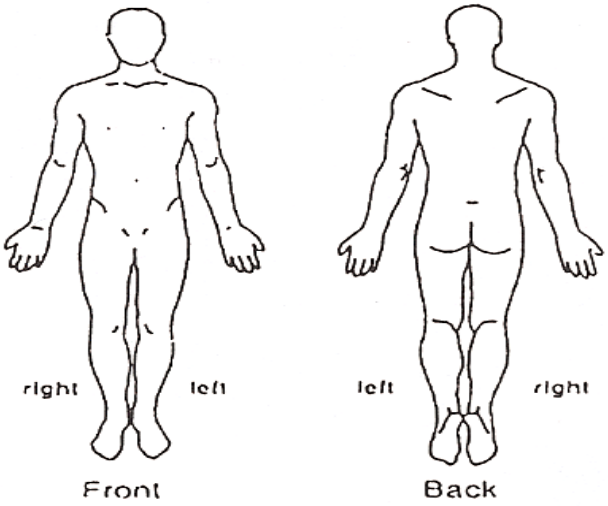
WOMEN ONLY: Have you had problems with your menstrual cycle, vaginal discharge or bleeding, hot flashes, swollen, painful breasts, or discharge from the nipples or other "female" conditions?
 Yes No **Explain**:_____

Are you pregnant? Yes No If yes, pregnancy in weeks? _____
Number of children & their ages:_____/_____

** Please mark all areas of pain by placing the appropriate letter from the list below, in the area of the body you are having pain. **

Aching **B**urning **C**ramping **D**ull

Sharp **N**umbness **T**ingling **O**ther



I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/ or therapeutic services, in accordance with this state's statutes.

Patient Signature: _____ Date: _____
Treating Doctor Signature: _____ Date: _____

For **INSURANCE PATIENTS** only: Please read and sign the following:

I hereby assign, transfer, and set over to Dr. Brittany Badon & Live Natural Chiropractic Center all of my rights, title, and interest to my medical benefits under my insurance policy. I authorize the release of medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether they are or not covered by my insurance.

Patient's Signature: _____ Date: _____

Patient Name: _____ Date:_____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

WITNESS:

_____	_____	_____
Printed Name	**Signature**	**Date**

Live Natural
Chiropractic Center

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996, Live Natural Chiropractic Center, LLC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION SECTION

I, _____ hereby authorize the use and disclosure of the following health information that pertains to me for the following purpose:

_____ Evaluation & Treatment secondary to an accident or injury

_____ Evaluation & Treatment of a non-acute condition

I authorize the following person to make these disclosures of my health information
Live Natural Chiropractic Center, its physicians and staff

I authorize the following persons or companies to receive these disclosures of my health information

_____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Live Natural Chiropractic Center. I further understand that by such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire 1 year from the date of last visited.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I SIGN THIS AUTHORIZATION OR NOT (NOTE: This paragraph may be modified if this authorization relates to a purpose for which conditioning is allowed. See 164.508 (b)(4)(1) through 164.508 (b)(4)(iv). In such case, you must describe the effect of a refusal to sign this authorization.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that Live Natural Chiropractic Center, LLC, its physicians and staff will receive compensation for the uses and disclosures that I have authorized.

_____ _____
Signature Date

REVOCATION SECTION

I hereby revoke this authorization

_____ _____
Signature Date