Lakeside Chiropractic

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Please complete in blue or black ink

Confidential Patient Health Record/Reactivation ***Today's Date*:___/____/_____**

How did you hear about us? ☐ **Family** _____ ☐ **Friend** _____ ☐ **Co-Worker** _____
☐ **Close to home/work** ☐ **Dr.** _____ ☐ **Yellow pages** ☐ **Drove by** ☐ **Hospital** ☐ **Insurance Plan**

Personal Information

Title: ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.** ☐ **Dr.** ☐ **Rev.** ☐ **Miss** ☐ **Prof.** ☐ **other:** _____

Last:_____ **First:**_____ **Middle:** _____

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III** ☐ **MD** ☐ **PhD** ☐ **DO** ☐ **Esq** ☐ **PA** ☐ **RN** ☐ **BSN** ☐ **other:** _____

Birth Date: ____ /____/_____ **Age:**_____ **Sex: Male / Female** **Social Security #:** _____-_____-_____

Primary Language: ☐ **English** ☐ **French** ☐ **German** ☐ **Spanish** ☐ **other:** _____

Driver's License #: _____ **State:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Eye Color: ☐ **blue** ☐ **brown** ☐ **green** ☐ **grey** ☐ **hazel** ☐ **other:** _____

Hair Color: ☐ **black** ☐ **blonde** ☐ **brown** ☐ **gray** ☐ **red** ☐ **white** ☐ **other:** _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Home Phone: (_____) _____-_____ **ext** _____ **Work Phone:** (_____) _____-_____ **ext** _____

Cell Phone: (_____) _____-_____ **ext** _____ **Fax #:** (_____) _____-_____ **ext** _____

Email Address: _____ **Spouses Name:** _____

Children (Names and Ages): _____

Emergency Contact

Title: ☐ **Miss** ☐ **Mrs.** ☐ **Ms.** ☐ **Master** ☐ **Mr.** ☐ **Dr.** ☐ **Prof.** ☐ **Rev.** ☐ **other:** _____

Last:_____ **First:**_____ **Middle:** _____

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III** ☐ **MD** ☐ **PhD** ☐ **DO** ☐ **Esq** ☐ **PA** ☐ **RN** ☐ **BSN** ☐ **other:** _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Home Phone: (_____) _____-_____ **ext** _____ **Cell Phone:** (_____) _____-_____ **ext** _____

Work Phone: (_____) _____-_____ **ext** _____ **Fax #:** (_____) _____-_____ **ext** _____

Employment Information

Business Name: _____

Address: _____ **Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Phone: (_____) _____-_____ **Fax #:** (_____) _____-_____

Employer's Email Address: _____

Occupation/Job Title: _____ **Job Description** _____

Current Health Condition

Unwanted Condition (Why you are here today?):_____

_____

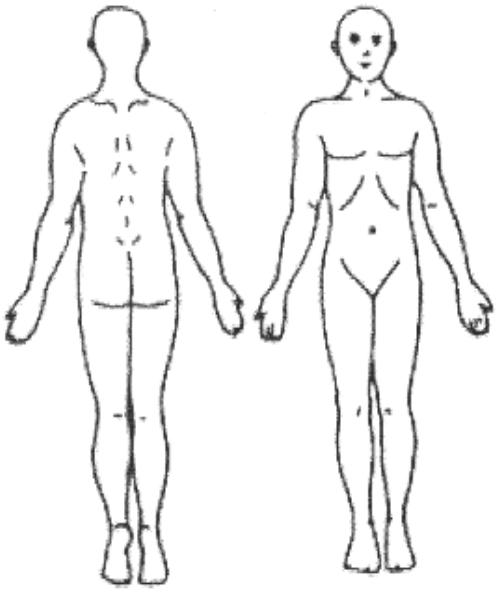
_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____/_____/_____

□ **Immediately** □ **Hours Later** □ **Days Later** □ **Other**

Please Explain: _____

_____

Has it ever occurred before? □ **Yes** □ **No. When?** _____

Is the Condition: □ **Auto Related** □ **Job Related** □ **Home Injury**

□ **Slip or Fall** □ **Lifting** □ **Slept Wrong** □ **Unknown Cause** □ **Other**

Explain: _____

_____

_____

Date of Accident: _____ **Time of Accident**: _____ **am /pm**

Do you SUFFER with ANY OTHER Condition than which you are now consulting us? _____

_____

_____

_____

□ **I have NOT previously seen a Chiropractor for this condition.**
□ **I saw Dr.** _____ **Date of last visit:** _____

□ **I have NOT seen my MD for this condition.**
□ **I saw Dr.** _____ **Type of Treatment:** _____ **Did it help? Y/N**

Please tell us about your health history.
Surgery -including diagnosis (why) and date: _____
_____
Fracture including location and date: _____
_____
Additional Diagnoses and Diagnosed by what Dr. (example: arthritis, diabetes, cancer)_____
_____

Current Medications:

Name	For What Condition	How long have you been taking ?

Have you been diagnosed with any condition in the area of (please circle yes or no):

Yes / No	Sinus	Yes / No	Allergy/Immunologic
Yes / No	Lungs	Yes / No	Neurologic
Yes / No	Heart	Yes / No	Psychiatric
Yes / No	Stomach	Yes / No	Covid Infx/Covid Vaccine
Yes / No	Bowels	Yes / No	Use Energy Drinks
Yes / No	Bladder	Additional	_____
Yes / No	Female/Male Reproductive Organs		

Please explain any yes: _____
_____
_____

Family History - Please check all that apply to any blood relatives.

☐ Arthritis ☐ Cancer ☐ Diabetes
☐ Fibromyalgia ☐ Heart Disease ☐ Spinal Stenosis
☐ Degenerative Joint Disease ☐ Degenerative Disc Disease
☐Osteoporosis ☐ Stroke/Vascular Disease

Continued on Back

Social History: Please check all that apply to you.

Tobacco Use: □ Have never smoked □ Former Smoker □ Current every day smoker □Current Occas Smoker □Have never used chew □Formerly used chew □ Currently use chew

Substance Use:□ never used illegal drugs □ not used illegal drugs since_____ □used i.d. for _____

Alcohol: □ Do not drink alcohol □social consumption only □ drink regularly (quantity) _____

Insurance Information:

Who Is Responsible For Your Bill? **YOU and… (mark appropriate box(es))** **□ Myself ONLY**

□ Spouse □ Worker's Comp □ Auto Insurance □ Medicare □ Other (be specific):_____

Personal Health Insurance Carrier: _____ **Health ID Card #: _____**

Policy Holder's Name: _____ **Group #: _____**

Policy Holder's Social Security #: _____-_____-_____ **Policy Holder's Date of Birth: _____**

Primary Care Physician: _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? □Yes □ No **Date:____/____/_____Time: _____am/pm**

Carrier: _____ **Policy # _____**

Carriers Phone #: (_____) _____-_____ **Adjuster: _____**

Claim #: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature: _____ Date: _____
Consent to treat a Minor: _____ Date: _____
Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: _____
Patient's Signature: _____ Date: _____