

# LIGHTHOUSE CHIROPRACTIC INTAKE & HISTORY

## Ages 13 through Adult

### PATIENT INFORMATION

Patient Name \_\_\_\_\_  
LAST NAME

\_\_\_\_\_  
FIRST NAME MIDDLE INITIAL

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthday \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered

Employer / School \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Contact Number \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

### HOW CAN WE HELP YOU?

What brings you in today? \_\_\_\_\_

If you are already experiencing a symptom, what is it? \_\_\_\_\_

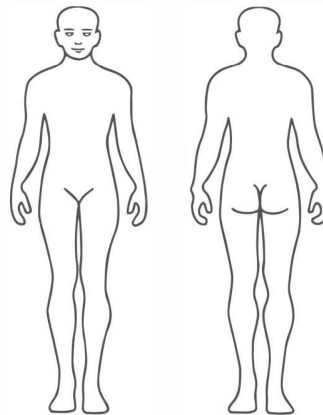
How bad is it? How intense are your symptoms? (circle)

0  1  2  3  4  5  6  7  8  9  10  
NO SYMPTOMS INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:

What does it feel like? (check where appropriate)

- Numbness
- Sharp
- Tingling
- Shooting
- Stiffness
- Burning
- Dull
- Throbbing
- Aching
- Stabbing
- Cramping
- Swelling
- Nagging
- Other \_\_\_\_\_



### IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue?

0  1  2  3  4  5  6  7  8  9  10  
NOT COMMITTED VERY COMMITTED

## PATIENT WELLNESS ASSESSMENT

### ILLNESS-WELLNESS CONTINUUM



On the arrow diagram above:

A. What number do you think represents your health today? \_\_\_\_\_

B. In what direction is your health currently headed? \_\_\_\_\_

What are your health goals?

IMMEDIATE \_\_\_\_\_

SHORT TERM \_\_\_\_\_

LONG TERM \_\_\_\_\_

## CHILDREN & PREGNANCY

How many children do you have? \_\_\_\_\_

Are you currently pregnant?  No  Yes, I am due \_\_\_\_\_

Childrens' ages? \_\_\_\_\_

Number of past pregnancies? \_\_\_\_\_

Childrens' health concerns? \_\_\_\_\_

Health concerns regarding this pregnancy? \_\_\_\_\_

## HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV              | <input type="checkbox"/> Circulation Issues                                   | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> Childhood Illness                                    | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Scoliosis       |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Depression   | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Shoulder Issues |
| <input type="checkbox"/> Arteriosclerosis      | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Hip Issues            | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Digestive Issues<br>(Constipation/Diarrhea/GERD/IBS) | <input type="checkbox"/> Immune Issues         | <input type="checkbox"/> TMJ Issues      |
| <input type="checkbox"/> Asthma/Allergies      | <input type="checkbox"/> Elbow/Wrist/Hand Issues                              | <input type="checkbox"/> Lymphatic Issues      | <input type="checkbox"/> Urinary Issues  |
| <input type="checkbox"/> Back Pain             | <input type="checkbox"/> Endocrine Issues (Thyroid)                           | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Osteoporosis    |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> Foot/Ankle Issues                                    | <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Gout   | <input type="checkbox"/> Reproductive Issues   | _____                                    |

## ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS (list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SUPPLEMENTS (list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. As a courtesy, Lighthouse Chiropractic will verify my insurance. I understand that **"VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF COVERAGE OR PAYMENT. IT WILL BE BASED ON MEDICAL NECESSITY, CONTRACT EXCLUSION AND ELIGIBILITY AT THE TIME OF SERVICE."** Furthermore, I understand that Lighthouse Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to Lighthouse Chiropractic will be credited to my account upon receipt. However, **I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.** I also understand that if I suspend or terminate my case and treatment, any fees for professional services rendered me will be immediately due and payable.

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Patient Name

Patient Signature

Date

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Guardian's Name

Guardian's Signature

Date

## Credit Card Policy

Please note that when you use a credit card in our office, it is **automatically saved** and will be used to pay for future appointments. **If you do not want to keep your card on file, please pay with cash or check.**

## Consent to Initiate Care

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Our only practice objective is to eliminate subluxation which interferes with the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_, have read and fully understand the above statements.  
(Please Print Name)

I hereby authorize the Doctor to provide any and all forms of evaluation, x-rays and care that may be indicated in connection with the patient above, and further authorize the consent that the Doctor chooses and employs such assistance as he sees fit. I also understand that prior to care, a full explanation of the procedure(s) involved will be given.

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Patient/Guardian Name

Patient/Guardian Signature

Date

# Notice of Privacy Practices Acknowledgement

## Lighthouse Chiropractic

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

OR

\_\_\_\_\_  
Signature of Personal Representative: Date

Authority of Personal Representative to Sign for Patient (check one):

Parent  Guardian  Power of Attorney  Other: \_\_\_\_\_

**Please Note: It is your right to refuse to sign this Acknowledgement.**

\_\_\_\_\_  
Lighthouse Chiropractic Office Use Only

I tried to obtain written Acknowledgement by individual note above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgment
- A communication barrier prevented us from obtaining acknowledgement
- The individual was unwilling to sign
- Other: \_\_\_\_\_

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

**Medical Information Release Form**  
(HIPPA Release Form)

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Patient's Date of Birth

**Release of Information**

\_\_\_\_\_ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

\_\_\_\_\_ My Insurance Company (only minimum necessary information needed for billing purposes)

\_\_\_\_\_ Spouse \_\_\_\_\_  
(Name – please print)

\_\_\_\_\_ Child(ren) \_\_\_\_\_  
(Name(s) – please print)

\_\_\_\_\_ Other \_\_\_\_\_  
(Name/relationship – please print)

\_\_\_\_\_ My information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date