Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THERECEPTIONIST

Patient Information

Today's Date : ________ Patient #________
日付

Name: ________________________________ Date of Birth: ______________
氏名 生年月日

Address:_________________________________ City:_________ State:______ Zip:________
住所 市/町 州 郵便番号

Phone: ___________________ Cell:_________________ E-mail______________________
自宅電話番号 携帯番号

SS # (last 4 digits): __________ Age: ________ ☐ Male ☐ Female
社会保障番号(後4桁) 年齢 男 女

Marital Status: ☐Married ☐ Single ☐Divorced ☐ Separated ☐Other
既婚 未婚 離婚 別居 その他

Name of Spouse or Nearest relative: ________________ Phone: ____________________
配偶者または近くに住む近親者の名前 電話

Your Occupation : ____________________ Your Employer : _______________________
あなたの職業 雇用主

Referred to this Office by: ☐Friend/Family Member - Name____________________
どのようにしてこのクリニックをお知りになりましたか？ 友達/家族の紹介 名前

☐Yellow Pages ☐Mail ☐Clinic Location ☐Other
電話帳 郵便広告 所在地 その他

Insured Name: ______________________ Insured's Employer: ______________________
保険名義人 保険名義人雇用主

Insured's SS#(last 4 digits): ________________ Insured's DOB _________________
保険名義人社会保障番号(後4桁) 保険名義人生年月日

Are you covered by more than one insurance company? ☐Yes ☐No
Name_________________________
二つ以上の保険会社に加入されていますか？ その場合,保険会社名を教えてください

MEDICAL/FAMILY HISTORY S=Self M=Mother F=Father

(Please indicate which condition have been experienced by the above by making appropriate boxes)
今まで感じたことのある症状に印をつけてください S=ご自身 M=母親 F=父親

S M F		S M F		S M F	
☐ ☐ ☐	osteoporosis (骨粗しょう症)	☐ ☐ ☐	dislocated joints(脱臼)	☐ ☐ ☐	neck pain (首の痛み)
☐ ☐ ☐	anemia(貧血)	☐ ☐ ☐	epilepsy(てんかん)	☐ ☐ ☐	nervousness(神経質)
☐ ☐ ☐	arthritis(関節炎)	☐ ☐ ☐	German measles(風疹)	☐ ☐ ☐	numbness (無感覚)
☐ ☐ ☐	asthma(喘息)	☐ ☐ ☐	headaches(頭痛)	☐ ☐ ☐	GERD(胃酸過多)
☐ ☐ ☐	back pain(腰痛)	☐ ☐ ☐	heart trouble(心臓疾患)	☐ ☐ ☐	poor circulation(冷え性)
☐ ☐ ☐	bladder trouble(排尿困難)	☐ ☐ ☐	reproductive disorders(不妊症)	☐ ☐ ☐	hepatitis(肝炎)
☐ ☐ ☐	bone fracture(骨折)	☐ ☐ ☐	high blood pressure(高血圧)	☐ ☐ ☐	stroke(脳卒中)
☐ ☐ ☐	cancer (ガン)	☐ ☐ ☐	indigestion(消化不良)	☐ ☐ ☐	muscular dystrophy(筋ジストロフィー)
☐ ☐ ☐	chest pain(胸の痛み)	☐ ☐ ☐	kidney disorder(腎臓疾患)	☐ ☐ ☐	rheumatism(リューマチ)
☐ ☐ ☐	concussion(脳しんとう)	☐ ☐ ☐	bowel control loss(排泄困難)	☐ ☐ ☐	serious injury(大ケガ)
☐ ☐ ☐	convulsions(ひきつけ)	☐ ☐ ☐	menstrual cramps(生理痛)	☐ ☐ ☐	sinus trouble(鼻腔炎)
☐ ☐ ☐	diabetes(糖尿病)	☐ ☐ ☐	MS (多発性硬化症)	☐ ☐ ☐	tuberculosis(結核)

Have you been treated by a physician for any health condition in the last year? ☐Yes ☐No
最近(過去1年程度)内科医にかかりましたか？

Describe Condition ______________________ Date of last Physical Exam__________
そのときの症状をお書きください 最後に診察を受けた日時

SURGICAL HISTORY:
過去外科医にかかった時の状態と日時をお書きください

1.______________________ Date: __________
2.______________________ Date: __________
3.______________________ Date: __________

Have you ever had a metal implant? ☐Yes ☐No
金属インプラントをされたことがありますか？

ACCIDENT HISTORY: ☐Job ☐Auto ☐Other 1.__________________ Date:__________
過去の事故について 仕事 交通事故 その他

☐Job ☐Auto ☐Other 2.__________________ Date__________

☐Job ☐Auto ☐Other 3.__________________ Date__________

Patient Name ______________________________

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms (1-10, with 1 being least serious)

症状を１から１０の強さで表してください

1. ______________________________ ______
2. ______________________________ ______
3. ______________________________ ______
4. ______________________________ ______
5. ______________________________ ______

SYMPTOMS ARE WORSE IN ☐MORNING ☐AFTERNOON ☐NIGHT

症状が悪化するのは 朝 午後 夜

WHEN AND HOW OCCURRED? ______________________________

いつ、どのようにしてその症状は起こりますか？

SYMPTOMS DEVELOPED FROM: ☐JOB RELATED INJURY ☐AUTO ACCIDENT ☐OTHER ☐ACCIDENT

症状の原因は ：職業に関係する怪我 交通事故 その他 事故

☐ILLNESS ☐UNKNOWN CAUSE ☐GRADUAL ONSET DATE OCCURRED: ______________

病気 原因不明 徐々に悪化 症状が始まった日(事故が起こった日)

SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ___DAY(S) _WEEK(S) __MONTH(S) __ YEAR(S)

症状が続いている期間 時間 日 週 月 年

SYMPTOMS/COMPLAINTS: ☐COME & GO ☐ARE CONSTANT

症状の状態 断続的に感じる 継続的に感じる

HAVE YOU EVER HAD THIS BEFORE: ☐NO ☐YES WHEN?

以前に同じ症状を感じたことがありますか？ いいえ はい いつ？

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

痛みの症状は何が原因だと考えますか？ ______________________________

NAME OF CURRENT FAMILY DOCTOR AND ADDRESS (IF KNOWN): ______________________________

ファミリードクターの名前,住所をお書きください(ご存知であれば)

MAY WE CONTACT YOUR DOCTOR REGARDING YOUR CARE HERE?

必要があればファミリードクターと連絡を取ってもよろしいですか？ ______________

ARE YOU ALLERGIC TO ANY MEDICATIONS ☐NO ☐YES WHAT KIND? ____________
薬にアレルギーがありますか？ いいえ はい どのような種類ですか

ARE YOU TAKING ANY MEDICATIONS ☐NO ☐YES (INCLUDING OTC AND BIRTH CONTROL)
現在,薬を服用中ですか？ いいえ はい (OTCと避妊薬を含む)

WHAT KIND? ____________
どのような種類ですか？

ARE YOU PREGNANT ☐NO ☐YES DATE OF LAST MENSTRUAL PERIOD ____________
現在妊娠していますか？ いいえ はい 最終月経日は？

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

あなたの症状を悪化させる(痛みを感じる)動作に印をつけてください

☐BENDING FORWARD 前屈 ☐BENDING BACKWARD 後屈 ☐REACHING 手を伸ばす ☐STRAINING AT STOOL 排便時のいきみ ☐COUGHING せき

☐SITTING 座る ☐TURNING HEAD 頭を回す ☐LIFTING 物を持ち上げる ☐SNEEZING くしゃみ ☐WALKING 歩く ☐LYING DOWN 横になる ☐STANDING 立つ

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:

あなたの症状を緩和させる動作に印をつけてください

☐BENDING かがむ ☐SITTING 座る ☐LIFTING 物を持ち上げる ☐STANDING 立つ ☐LYING DOWN 横になる

☐TURNING HEAD 頭を回す ☐REACHING 手を伸ばす ☐WALKING 歩く

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

その他,あなたが感じる症状に印をつけてください

☐blurred vision かすみ目 ☐buzzing in ears 耳鳴り(低音) ☐cold feet 足の冷え ☐cold hands 手の冷え ☐cold sweats 冷や汗 ☐concentration loss/confusion 集中力の低下

☐constipation 便秘 ☐depression /weeping spells うつ/泣く ☐diarrhea 下痢 ☐dizziness 目まい ☐face flushed 顔のほてり ☐fainting 失神 ☐fatigue 疲労 ☐fever 発熱

☐head seems too heavy 頭が重く感じる ☐headaches 頭痛 ☐insomnia 不眠症 ☐light bothers eyes 光過敏 ☐loss of balance バランス感覚の異常 ☐loss of smell 嗅覚異常

☐loss of taste 味覚異常 ☐low resistance to colds 風邪をひきやすい ☐muscle jerking 筋肉の痙攣 ☐numbness in fingers 指先の麻痺 ☐numbness in toes 足先の麻痺 ☐pins and needles in arms 刺すような腕の痛み ☐pins and needles in legs 刺すような足の痛み ☐ringing in ears 耳鳴り(高音) ☐shortness of breath 息切れ ☐stiff neck 首のこわばり ☐stomach upset 胸焼け

WHAT DO YOU WANT TO ACHIEVE WITH YOUR CARE HERE? ____________

どのような症状改善を希望されますか？(例: 一時的な痛みの改善,根本的な治療等…)

Patient's Signature: ____________ Date: ____________

HEBRON Chiropractic & Rehabilitation

Jonathan Langley, DC

2030 Northside Drive Suite C, Hebron, KY 41048

859.372.0888 Office   206.333.1232 Fax

X-Ray Consent:

I ____, do hereby give my consent to allow Hebron Chiropractic and Rehabilitation and its representatives to take X-Rays as deemed appropriate by the examining Doctor of Chiropractic.

____
Signature

____
Date

FEMALES ONLY

I hereby declare that to my knowledge, I am not pregnant.

____
Signature

____
Date

Authorization of Treatment to Minor (if applicable):

I, ____________________________, do hereby give my consent to allow Hebron
(please print)

Chiropractic and its representatives to treat my son/daughter, ______________________,
(please print)

as deemed appropriate by the examining Doctor of Chiropractic.

__________________________ __________________________
Signature Date

Hebron Chiropractic - Informed Consent to Chiropractic Care

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neurospinal system.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential. I understand that my care at Hebron Chiropractic will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and neurospinal assessments by Dr. Jonathan Langley, DC and/or Dr. Stacey Lang, DC. Understanding that every body has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed. Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that, unlike many other health care professions, the risks associated in receiving chiropractic care are extremely minimal. In recent years there has been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%. The risk of stroke after a chiropractic adjustment is 0.00025%. The most common complaint of chiropractic treatment is ache or stiffness at site of adjustment. As your chiropractor, I am aware of these complications, and in order to minimize their occurrence, I will take precautions. These precautions include, but are not limited to, my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This exam may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant and/or have a pacemaker. If you are pregnant or have a pacemaker, you should tell me when I take your clinical history. It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, emotional ailments, or to give advice about medical conditions. If while being served you become concerned about symptoms or conditions, we suggest you seek the help of a symptom, sickness and disease care professional.

Our primary goal is to release life and healing energy in the body, through the detection and correction of vertebral subluxation.

I, ______________________________ have read and fully understand the above statements. (print name)
I have also had an opportunity to ask questions about its content. By signing below I agree to the abovementioned chiropractic procedures. I intend this consent form to cover
the entire course of my care in this office.

____ ______________

(Patient Signature) (date)

____ ______________

(Dr. Signature) (date)

(Information released from: The National Center for Health Statistics USA, 1993 and A Risk Assessment for Cervical Manipulation vs. Non-Steroid Antiinflammatory Drugs for the Treatment of Neck Pain, JMPT, Oct. 1995)

HEBRON CHIROPRACTIC II, INC.
AUTHORIZATION OF TREATMENT
ASSIGNMENT OF INSURANCE BENEFITS
FINANCIAL AGREEMENT

Authorization must be signed by patient if age 18 or over or by a minor (under 18) emancipated or otherwise eligible pursuant to KRS 214.185 (See Consent Procedure); or by the parent or legal guardian for any other minor or by the patient's guardian if the patient is disabled.

PATIENT:__________________________________ DATE:____________________
(Please Print)

1. I hereby consent to treatment by Jonathan Langley, DC, and/or Stacey Lang, DC believing that I am suffering from a condition requiring chiropractic and/or nutritional treatment, and authorize such care and diagnostic procedures. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment of any condition.

2. I understand that no assurances or guarantees have been given by anyone concerning this treatment or the results that may be obtained.

3. I acknowledge that it has been explained to me the diagnostic and treatment procedures to be provided are limited to chiropractic and/or nutritional treatment.

4. I hereby authorize treatments and/or procedures and the use of same or further medical study. I further authorize the treating doctors to use their discretion in allowing persons to observe such treatment, testing or treatments in the furtherance of diagnostic research.

5. I hereby authorize HEBRON CHIROPRACTIC II, INC to release medical and any psychological information to third party payors.

6. I understand that charges will be made for treatment and the use of laboratory and diagnostic testing and any other services performed in accordance with the prescribed treatment plan all of which I agree to pay. I hereby assign all hospital insurance benefits, workers compensation benefits, personal injury protection benefits and any other insurance benefits that may arise to HEBRON CHIROPRACTIC II, INC. A photocopy of this authorization shall be considered as effective and valid as the original.

7. I understand that should the status of my account become delinquent, any charges resulting from the collection of said account are incurred by myself. I further understand that should my account be sent to our collections attorneys after 3 written notices, a 35% fee will be assessed to my account to cover collections fees.

Signing below acknowledges that you understand these guidelines and were given a copy of the NOTICE OF PRIVACY PRACTICES in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

____
PATIENT'S SIGNATURE (If minor, parent or guardian)

____
Witness signature (doctor or staff can sign)