Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date:_____ Patient # _____ (office staff will input)

Name:_____Date of Birth:_____

Address:_____ City:_____ State:____ Zip:_____

Phone:_____ Cell: _____ E-mail: _____

SS # (last 4 digits):_____ Age:_____ ❑ Male ❑ Female

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Partnered ❑Widow/er

Name of Spouse or Nearest Relative:_____ Phone:_____

Your Occupation_____ Your Employer:_____

How did you find out about us?: ❑Friend/Family Member - Name?_____

❑ Angie's List ❑Internet ❑ Mailer/Flyer ❑Clinic Location ❑Other_____

Insured Name.:_____Insured's Employer: _____

Insured's SS #(last 4 digits):_____ Insured DOB _____

Are you covered by more than one insurance company? ❑Yes ❑No Name _____

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

_____

MAY WE CONTACT YOUR DOCTOR REGARDING YOUR CARE HERE?_____

Have you ever been treated by a chiropractor before? ❑Yes ❑No If yes, when was the last time? _____
Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition Treated_____ Date of Last Physical Exam_____

PATIENT NAME _____

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

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	osteoporosis	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	GERD
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	stroke

SURGICAL HISTORY:

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1. _____ Date:_____
❑Job ❑Auto ❑Other 2._____Date:_____
❑Job ❑Auto ❑Other 3._____Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate your symptoms (1-10, with 1 being least serious, 10 being the most serious)

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT ❑CONSTANT

WHEN AND HOW OCCURRED?_____

_____

Any other complaints (headache, stiffness, etc.) to list that are not major, but bother you _____

_____

PATIENT NAME _____

MAJOR COMPLAINTS (continued):

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT
❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED:_____

SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)

SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT
HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES
WHEN?_____

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

_____ _____

ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____
ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES (INCLUDING OTC AND BIRTH CONTROL)

IF YES, WHAT KIND?_____

ARE YOU PREGNANT? ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑BENDING FORWARD ❑BENDING BACKWARD ❑REACHING ❑STRAINING AT STOOL ❑COUGHING
❑SITTING ❑TURNING HEAD ❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

Any other aggravating activities or remedies _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

Any other relieving activities or remedies_____

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion
❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever
❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste
❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms
❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

Any other symptoms you have to share:
_____

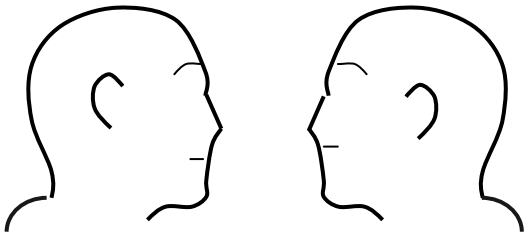
WHAT DO YOU WANT TO ACHIEVE WITH YOUR CARE HERE? _____

_____

Patient's Signature:_____ Date:_____

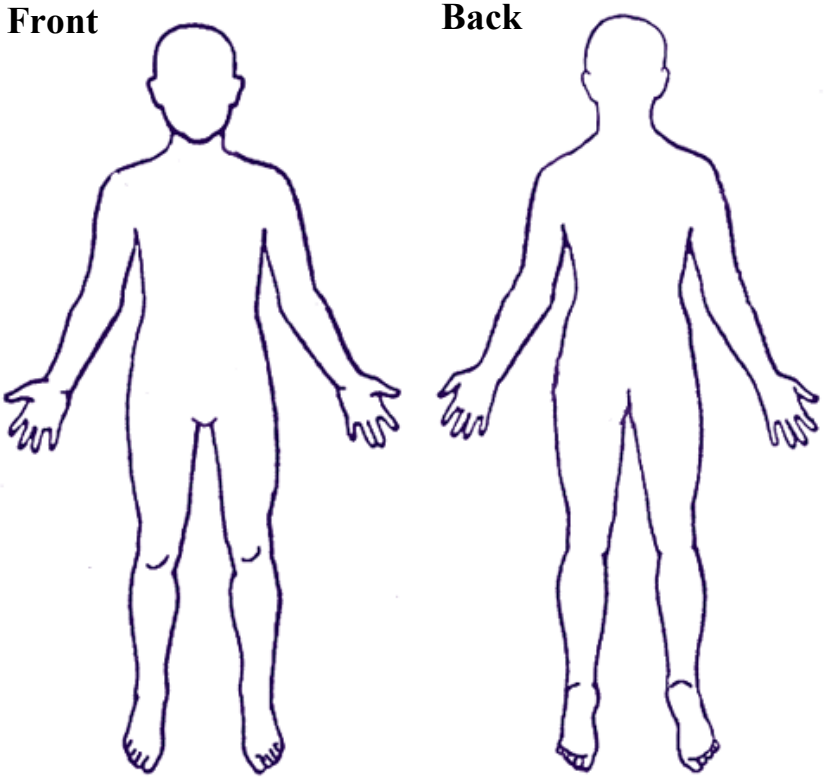
(this box to be filled out by staff) DOCTOR _____
DATE OF VISIT ___/___/20___ Patient_____Age_____
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION
FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms
_____
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint?
_____

Right **Left**



SUBJECTIVE PAIN ASSESSMENT

Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE	LITTLE		MEDIUM			SEVERE				EXCRUCIATING	

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

_____ _____

Activities of Daily Living

Patient Name _____ Date _____

Think about your life for a moment. How does your health condition affect you, your work, and your loved ones? Put a number next to any of the following activities that are affected by your condition(s).

1 = I am aware of my problem when I do this activity (Mild)
2 = I don't want to do this activity because of my problems (Moderate)
3 = I can't do this activity at all (Severe)

Basic Activities

Bending _____	Kneeling_____	Rising Out of Chair_____	Bathing_____
Climbing Stairs_____	Lifting_____	Sitting_____	Dressing_____
Falling Asleep _____	Looking Over Shoulder_____	Standing_____	Hair Care_____
Staying Asleep_____	Lying Down_____	Walking_____	Makeup/Shaving_____

Family/Daily Living

Child Care_____	Housework_____	Reading_____	Driving_____
Computer Use _____	Lifting Children_____	Pet Care_____	Yard Work_____
Concentrating_____	Carrying Groceries_____	(optional) Spiritual Life _____	(optional) Sexual Activity _____

Work

Using Telephone_____	Desk Work_____	Physical labor _____	Keeping focus _____
Attendance _____	Ability to provide financially for self and/or family _____		

Recreational

Exercising _____	Relaxing _____	Traveling _____	Socializing _____

Hobbies (List hobbies and rate 1-3) _____ _____

_____ _____

Sports (List hobbies and rate 1-3) _____ _____

_____ _____

After filling out the above, how concerned are you overall about your condition? Check which one applies most:

_____ I am **mildly** concerned about how my current condition(s) affects myself, my work, and my loved ones.
_____ I am **moderately** concerned about how my current condition(s) affects myself, my work, and my loved ones.
_____ I am **extremely** concerned about how my current condition(s) affects myself, my work, and my loved ones.

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)

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 & 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

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____, 20___

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By_____
Signature of Parent/Guardian (circle one)