Date: _____/_____/_____ VRC# _____

(Staff use only)

LIFE IS GOOD CHIROPRACTIC
CONFIDENTIAL CASE HISTORY

Name _____ Age _____ Birth Date _____ Sex: M or F

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____Email Address _____

Occupation _____ Marital Status: M S W D #Children_____ Spouse's Name_____

How did you hear about our office? _____

Health Information

Have you had previous chiropractic care? _____ If yes, when? _____

I am here for wellness care only _____

1. What is your primary complaint: _____

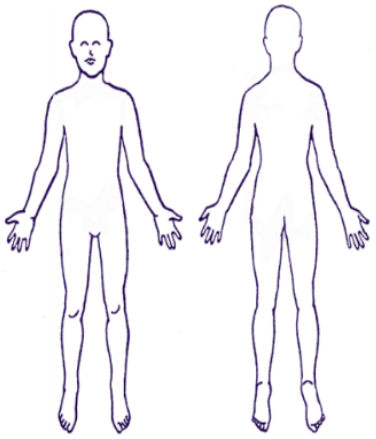
Other Complaints: _____

2. When did the primary symptom first start? _____

3. How did the primary Symptom first Start? _____

4. Have you had this or similar conditions in the past?_____

Please mark on the diagram the area of your discomfort



5. How would you describe your primary complaint?
(Check more than one if necessary to describe your problem)

____Stiffness ____Weakness ____ Sharp ____Dull ____Burning
____ Numbness & Tingling ____Pressure ____Throbbing ____ Tearing ____Achy
____ Soreness ____Travels ____Knot ____ Makes a grinding noise

6. How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%
(Intermittent) (Constant)

7.What activities aggravate your condition?(Check more than one if necessary to describe your problem)

__Working	__Lifting	__Standing	__Cauging	__Lying down
__Driving	__Walking	__Chores	__Stress	__Running
__Exercising	__Flexion	__Extension	__Sleeping	__Getting dressed
__Yard Work	__Doing dishes	__Sweep/Vacuum	__Sitting long periods of time	
Turning __Left or__ Right	__Walking up stairs	__Sitting after standing		
Bending _Left or __Right	__ Walking down stairs	_Standing after sitting		

8. It interferes with: ____Work ____Sleep ____Walking ____Sitting ____Hobbies ____Leisure

9. What alleviates your condition? (Check more than one if necessary to describe your problem)
___Resting ___ Sitting ___Standing ___Using ice ____Using heat ____Stretching ____Moving around ____ Adjustments ___Laying down ____Sleeping ____Exercise ____Massage ____Prescription medication ____OTC medication ____Taking time off work

10. How long has it been since you really felt good? _____

11. Other doctors who treated this condition _____

12. List surgical operations and years: _____

13. Medications you now take: ___Pain killer's ___ Nerve pills ___ Muscle relaxes ___Insulin ___Hormone ___Tranquilizer ___ Anti Inflammatory ___Allergy meds ___Mood related drugs ___ Blood Pressure ____No Meds
Other meds _____

14. Have you been in an auto accident? _____ Past Year _____ Past 5 years _____ Over 5 years _____ Never
Describe: _____

15. Have you had any personal injury or accident? ____ Past Year ____ Past 5 years _____ Over 5 years _____ None
Describe: _____

Research is showing that many of our health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Did you have any severe childhood illness? Yes / No / Unsure Do/ did you drink alcohol? Yes / No / Unsure
Was there a prolonged use of medication? Yes / No / Unsure Do/ did you smoke? Yes / No / Unsure

Have you suffered from? Please mark P for Past, C for Currently, N for Never and or O for Occasional

___Asthma	___ Pain between shoulders	___Pain down back of leg	___Tension
___Sinus Trouble	___ Shoulder pain	___Numbness in toes / feet	___Nervousness
___Sleep Disorders	___Arm pain	___Concentration problems	___Cancer
___Digestive Disorders	___Elbow pain	___Menstral pain/ irregular	___Arthritis
___Allergies	___Hand/finger/wrist pain	___Pins & needles	___Fatigue
___Heart Trouble	___Carpal tunnel	___Cold feet/ Cold hands	Other: _____
___Diabetes	___Low back pain	___Dizziness	
___Numbness in fingers/hands	___Mid back pain	___Loss of balance	
___Headaches	___Hip pain / Thigh pain	___Ringing/ Buzzing ears	
___Neck pain	___ Knee pain	___Mood swings /Depression	

Family History

1. Does anyone in your family suffer with the same condition(s) ____Yes ____No
If yes whom ___Grandmother____ Grandfather___ Mother ____ Father ____ Sister(s) ____ Brother(s) ____ Son(s) ____Daughter(s)
2. Any other hereditary conditions the doctor should be aware of? ____ Yes ____No If yes _____

Female Only: Is there any chance that you may be pregnant if yes, due date ____/____/____ No_____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job-related injury? ____Yes ___No

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me with collecting from the insurance company and that any amount authorized to be paid directly to this Chiropractic office, will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged to me directly at time of service and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

Print Name: _____

Patient's Signature: _____

Date: _____/_____/_____

Parent or Guardian Signature: _____

Doctor's Signature: _____ Date: _____/_____/_____

VRC#_____
(Office use only)

Life Is Good Chiropractic

1807 Route 209, Brodheadsville, PA 18322

Name: _____ Age:_____ Date: _____

Primary Health Concern: _____
(Area of main complaint)

(Circle only one number for each)

What is this pain ***right now***?	0	1	2	3	4	5	6	7	8	9	10 (worst)
What is this pain on ***average***?	0	1	2	3	4	5	6	7	8	9	10
What is this pain at its ***best***?	0	1	2	3	4	5	6	7	8	9	10
What is this pain at its ***worst***?	0	1	2	3	4	5	6	7	8	9	10

Secondary Health Concern: _____

(Circle only one number for each)

What is this pain ***right now***?	0	1	2	3	4	5	6	7	8	9	10
What is this pain on ***average***?	0	1	2	3	4	5	6	7	8	9	10
What is this pain at its ***best***?	0	1	2	3	4	5	6	7	8	9	10
What is this pain at its ***worst***?	0	1	2	3	4	5	6	7	8	9	10

Other Health Concern: _____

(Circle only one number for each)

What is this pain ***right now***?	0	1	2	3	4	5	6	7	8	9	10
What is this pain on ***average***?	0	1	2	3	4	5	6	7	8	9	10
What is this pain at its ***best***?	0	1	2	3	4	5	6	7	8	9	10
What is this pain at its ***worst***?	0	1	2	3	4	5	6	7	8	9	10

Any other comments:

_____

_____

_____

_____

Patient Name_____ VRC_____
(Staff use only)

Life Is Good Chiropractic

Informed Consent

Regarding: Chiropractic Adjustments

I have been advised that chiropractic care, like all forms of health care, holds certain risk. While the risk are most often very minimal, in rare cases, complications such as sprain/strain, irritation of disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance one instance per one million to one per two million, have been associated with chiropractic adjustments.

Care objectives as well as risk associated with chiropractic adjustments provided at Life Is Good Chiropractic, LLC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient or Authorized Person's Signature: **Date:** **Witness Initials**

_____ _____ _____

Regarding: X-rays/Imaging Studies

Females Only → Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

□ The first day of last menstrual cycle was on_____-_____-_____ (Date)
□ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risk associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient or Authorized Person's Signature: **Date:** **Witness Initials**

_____ _____ _____

VRC# _____
(Staff use only)

Medical Information Release Form
(HIPAA Release Form)

Name:_____ Date of Birth:_____
Emergency Contact Information:
Name: _____
Relationship:_____
Phone Number:_____

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:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone

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

Messages:

Please call [ ] my home [ ] my work [ ] my mobile number:_____

Do we have your permission to send a text message ? Yes No

Do you prefer ? [ ] A phone call [ ] A text message

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____
The best time to reach me is (day)_____between (time)_____

Signed:_____Date:_____

Witness: _____ Date: _____

LIFE IS GOOD CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr Bryn Gillow at (570) 992-2929. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

VRC _____
(Staff Use Only)

Patient initials: _____ -retaining page 1 of 2

LIFE IS GOOD CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Life is Good Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Print Patient's Name:_____

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____