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: ____

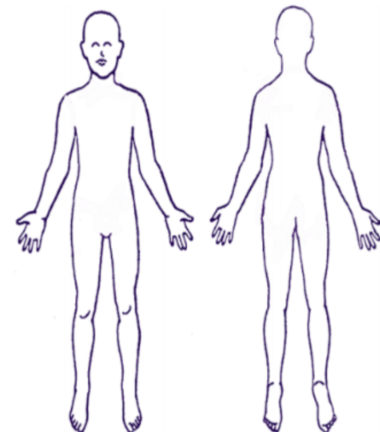
Other Complaints: ____

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
Was there a prolonged use of medication? Yes / No / Unsure
Do/ did you drink alcohol? 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
___Sinus Trouble
___Sleep Disorders
___Digestive Disorders
___Allergies
___Heart Trouble
___Diabetes
___Numbness in fingers/hands
___Headaches
___Neck pain
___ Pain between shoulders
___ Shoulder pain
___Arm pain
___Elbow pain
___Hand/finger/wrist pain
___Carpal tunnel
___Low back pain
___Mid back pain
___Hip pain / Thigh pain
___ Knee pain
___Pain down back of leg
___Numbness in toes / feet
___Concentration problems
___Menstral pain/ irregular
___Pins & needles
___Cold feet/ Cold hands
___Dizziness
___Loss of balance
___Ringing/ Buzzing ears
___Mood swings /Depression
___Tension
___Nervousness
___Cancer
___Arthritis
___Fatigue
Other: ___________________

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, 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:

____

____

____

____

Life Is Good Chiropractic

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process, you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, palpation, and radiological examination (x-rays).

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.

In addition to the benefits of chiropractic care, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE LIFE IS GOOD CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATED THIS ____ DAY OF _____________, 20___

___________________________ ___________________________
Patient Signature Doctor's Signature

Parental Consent for Minor Patient:

Patient Name: _____________________________
Patient age: ___________ DOB: ____________
Printed name of person legally authorized to sign for Patient: _________________________________
Signature: _______________________________
Relationship to Patient: ____________________

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _________________________________
Signature: _______________________________
Relationship to Patient: ____________________

Remarks:

Patient Name____________________________ VRC_____________

Life Is Good Chiropractic

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: _____________________