CONFIDENTIAL PATIENT INFORMATION

You deserve to be healthy. Unfortunately, accidents and other challenges can cause a disruption to your health. Through consultation, examination and natural chiropractic care, we will work together to restore your body's innate ability to heal. Your answers to these questions help us to determine what you need to get better quickly.

Name: _____ Address: _____

Home Phone: _____ City: _____ State:_____ Zip:_____

Mobile Phone: _____ Age: _____ Birth date: _____

Occupation: _____ Marital Status: ❑M ❑S ❑W ❑D Spouse's Name: _____

# of Children_____ Employer:_____

E-Mail Address: _____@_____

Who may we thank for referring you? _____

Health Information

What health goals you would like to accomplish through chiropractic care?

- ❑ Symptomatic relief / Feel better quickly
- ❑ Have a Healthier Spine
- ❑ Have a Healthier Body by treating my Nerve System
- ❑ Preventative / Wellness Care

Main Complaint: _____

_____

How long have you had this condition? _____

Have you had previous Chiropractic Care? ❑ Yes ❑ No

Does this condition affect your work? ❑ Yes ❑ No

Does this condition affect your family or social life? ❑ Yes ❑ No

What aggravates your condition? _____

What helps your condition? _____

Have you seen other doctors for this condition?

_____

What medications are you taking? _____

Any home remedies? _____

Have you had any surgery/falls/accidents? ❑ Yes ❑ No

Please describe:

_____

Have you experienced any side effects from drugs/surgery? _____

Date of last physical examination? _____

Are you Pregnant? ❑ Yes ❑ No

Is there a family history of:Heart Disease Arthritis

Cancer Diabetes Other _____

Father's side: ❑	❑	❑	❑	❑	
Mother's side: ❑	❑	❑	❑	❑	

Do you suffer from:

(*(Check all that apply)*

Headaches	❑
Neck Pain	❑
Arm or Shoulder Pain	❑
Back Pain	❑
Hip or Leg Pain	❑
Chest Pain	❑
Abdominal Pain	❑
Sinus Trouble	❑
Heart Trouble	❑
Palpitation	❑
Circulatory	❑
High / Low Blood Pressure	❑
Female Problems	❑
Prostate Problems	❑
Kidney Problems	❑
Bladder Problems	❑
Lung or Bronchial Disorder	❑
Digestive Disorder	❑
Constipation	❑
Loose Stool	❑
Diabetes	❑
Swollen Joints	❑
Insomnia	❑
Dizziness	❑
Numbness	❑
Nervousness	❑
Depression	❑
General Fatigue	❑
Morning Fatigue	❑
Anemia	❑
Poor Memory	❑
Hot Flashes	❑

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Landi Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to LFC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable.

Patient Signature_____ Date _____

Complete only for ACCIDENT INFORMATION

*Date*_____ *Time*_____ *Location*_____

How did the accident occur? ❑ Auto Collision ❑ Other

If Auto accident, were you ❑ Driver ❑ Passenger ❑ Pedestrian

If auto collision, were you struck from

❑ Behind ❑ Right Side ❑ Left Side ❑ Front ❑ Parked

What speed were you traveling? _____

What speed was the other driver traveling? _____

Where were you looking at the time of impact? _____

Did you have your seat belt on? ❑ Yes ❑ No

Did your head hit the headrest? ❑ Yes ❑ No

Did your car strike the others incolved? ❑ Yes ❑ No

Or did the other car strike yours? ❑ Yes ❑ No

As a result of the accident, were traffic citations issued to you? ❑ Yes ❑ No

List the extent of the injuries as you know them

_____

Did you require post-accident hospitalization? ❑ Yes ❑ No

Were X-rays Taken? ❑ Yes ❑ No

Check the symptoms you have noticed since the accident:

❑ Headache	❑ Dizziness	❑ Light Bother Eyes	❑ Diarrhea
❑ Neck Pain	❑ Heavy Head	❑ Memory Loss	❑ Feet Cold
❑ Stiff Neck	❑ Pins/Needles in Arms	❑ Ringing in Ears	❑ Hands Cold
❑ Sleeping Problems	❑ Pins/Needles in Legs	❑ Face flushed	❑ Upset Stomach
❑ Back Pain	❑ Numbness in Fingers	❑ Buzzing in Ears	❑ Constipation
❑ Nervousness	❑ Numbness in Toes	❑ Loss of Balance	❑ Cold Swears
❑ Tension	❑ Shortness of Breath	❑ Fainting	❑ Fever
❑ Irritability	❑ Fatigue	❑ Loss of Smell	

❑ Symptoms Other Than Above _____

Have you lost any days of work? ❑ Yes ❑ No Dates: _____

Insurance companies involved: _____

Have you been contacted by an insurance adjuster or company representative regarding this claim?

❑ Yes ❑ No

Do you have an attorney that has advised you in this care? ❑ Yes ❑ No

Name: _____

Address: _____

Telephone: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

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

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

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 evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to 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.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____

HIPPA Statement/Release

Patient's Name_____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES LANDI FAMILY CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

> I give permission to Landi Family Chiropractic to use the following information, but not limited to: my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, recall ("We haven't seen you") cards, using your name or image of you (or dependent) on our message board or Digital Messenger video system for purpose of internal testimonial or referral thank you, sending newsletters, leaving voicemail or e-mailing.

> If Landi Family Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

(OPEN ROOM ADJUSTING AUTHORIZATION)

> I give Landi Family Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private; the doctor will provide a room for these conversations.

> By signing this form you are giving Landi Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Landi Family Chiropractic. The written notice must contain the following information:

Your name, Social Security number and date of birth,
A clear statement of your intent to revoke this AUTHORIZATION,
The date of your request and your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Landi Family Chiropractic for its own use/disclosure of PHI.
(Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Landi Family Chiropractic will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU * *

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

Signature of Personal Representative
(Guardian)

_____

Description of Representative's Authority to Act for
Patient: