Lodi Chiropractic Patient Information

Last Name: First Name: MI: Spouse:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Widow	
Email: Cell #:			Birth date: / /		Age:	Sex:
Address:		City:			State:	
ZIP Code:	Soc. Sec. #:		Home Phone:			
Occupation:	Employer:				Emp ph:	

Medical Care Information GHC/PHYPLUS/Other _____ PLEASE SHOW YOUR INSURANCE CARD TO FRONT DESK

HIPPA:

Lodi Chiropractic Clinic. recognizes the importance of our patients' trust. Keeping our patients' personal information confidential is a top priority for all Lodi Chiropractic employees and staff.
This notice, which is required by state and federal law, explains our Privacy Policies.
1) We will safeguard, according to strict standards of security and confidentiality, nonpublic, personal information our patients share with us. "Nonpublic, personal information," for example, would include such information as your name, address, social security number, and credit information. We will maintain safeguards, physical and electronic, to protect that information. We will conduct our business in a manner that keeps personal customer information secure.
2) We will limit the collection and use of customer information to the minimum we require to deliver superior service and to administer our business. We collect private information about patients from the following sources:
• From patients on new patient information or accident forms;
• From information obtained during exams or daily treatments;
3) It is our policy that only authorized Lodi Chiropractic Clinic employees and staff who need to know your personal information will access and use it. Lodi Chiropractic Clinic employees who violate our Privacy Policies are subject to the disciplinary process.
4) It is our policy that we will not share personal customer information (either current or former patients) outside Lodi Chiropractic for any purpose other than the administration of your patient account, unless the disclosure has been authorized by the patient and is permitted or required by law.
5) Whenever we retain other organizations to provide support services on behalf of Lodi Chiropractic, we will require them to protect patients' personal information.
6) To help us keep your personal information up-to-date and accurate, please contact the Lodi Chiropractic staff person if there are changes.
7) When necessary, we will review and revise our Privacy Policies to protect our patients.

INFORMED CONSENT:

I understand that as with any medical procedure there are possible risks. However complications due to chiropractic manipulation are as rare as risks from taking a single aspirin. I hereby acknowledge that I am voluntarily submitting to health care procedures at Lodi Chiropractic Clinic.

Signature: _____ Date: _____

Past Surgeries
(approximate dates, list any complications)

Prescription Medications
(Name, reason for prescription, dosage)

Past Traumas-

Broken Bones (explain any complications):

Serious Illness (explain any complications):

Motor Vehicle Accidents (explain any complications:

Concussions:

Other:

Misc. Health History

Work History

☐ Full - Part
☐ Unemployed
☐ Retired

Type of work:

Tobacco Use

☐ Never
☐ Former
☐ Current

Smoker – Chew
Cigar – Pipe

#per day: _____

Alcohol/drug Use:

Do you use alcohol Y-N
drinks per week ____

Do you use drugs Y-N

Beer – Wine – Liquor
Marijuana – Recreational

Exercise:

☐ Regular routine
☐ Sporadically
☐ Never

Type of Exercise:

How Often? _____

Diet:

☐ Good
☐ Fair
☐ Poor

Would you like advise on diet? Y-N

Allergies-

Past/Current Medical History (Circle)

Blood pressure Heart problems Fainting/Dizziness Migraines
Lung problems Asthma High cholesterol Glaucoma Arthritis
Anxiety Depression Osteoporosis Blood clotting disorders
Diabetes Hernia Cancer Hyperthyroidism Hypothyroidism
Recurrent UTI Bladder problems Kidney problems Kidneys Stones
Heart Attack Stroke Concussion Brain trauma Seizures
Digestion problems Heartburn Acid Reflux Constipation /Diarrhea

Other:

Explain:

Family History *Check all that apply*

	Alcohol/Drug Abuse	Asthma	Cancer (type:)	Emphysema/COPD/Lung related	Depression/Anxiety	Bipolar/Suicide/Mental Related	Diabetes	Early Dealth	Heart Disease	High Blood Pressure	Kidney Disease	Stroke	Alzheimer	Thyroid Disesase	Migraines	Autoimmune	Other:	Comments:
Mother																		
Father																		
Brother																		
Sister																		
Child																		
Maternal GM																		
Maternal GF																		
Paternal GM																		
Paternal GF																		
Other:																		

Other Providers/Specialists

Specialist	*Name*	*Location*	*Last Visit*
Previous Chiropractor			
Primary Care Physician			
Cardiologist			
OB/GYN – Midwife			
Neurology			
Other(s):			

How can we help you and what you your health goals?

☐ Wellness care ☐ Injury Recovery ☐ Pain/Symptom Relief ☐ Other: _____

Please list any health goals you have that we can help you reach: _____

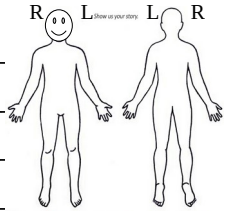
Please list you expectations for care here at the clinic: _____

If you are experiencing symptoms, please describe: _____

When did symptoms appear? _____ Since they began are they: Worse – Better – Same

How often do the symptoms occur? <25% / 25-50% / 50-75% / <75% of the HOUR / DAY / WEEK / MONTH

CONSTANT / INTERMITTENT / OCCASIONAL / RARE



Have you been treated for the symptoms: Y – N , explain:_____

Has this happened before? Y – N , explain: _____

Does anything makes the symptoms worse? _____

Does anything relieve the symptoms? _____

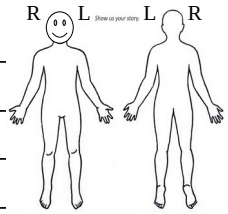
Rate the symptoms on a 0-10 scale (0 is no symptoms, 10 is severe symptoms) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

If you are experiencing additional symptoms, please describe: _____

When did symptoms appear? _____ Since they began are they: Worse – Better – Same

How often do the symptoms occur? <25% / 25-50% / 50-75% / <75% of the HOUR / DAY / WEEK / MONTH

CONSTANT / INTERMITTENT / OCCASIONAL / RARE



Have you been treated for the symptoms: Y – N , explain:_____

Has this happened before? Y – N , explain: _____

Does anything makes the symptoms worse? _____

Does anything relieve the symptoms? _____

Rate the symptoms on a 0-10 scale (0 is no symptoms, 10 is severe symptoms) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How did you find our clinic?

Phone Book – Internet – Referral – Cruise Day Magazine – Parade – Other: _____

Is there anything else you would like the doctor to know?