Leingang
CHIROPRACTIC & WELLNESS

**How did you hear of us?**_____ **If referred, by whom?**_____

## Patient Information

Last Name:_____First:_____ M.I. _____
Address:_____ City:_____
State:_____Zip Code:_____ Gender: M / F / Other Number of Children:_____
Phone #:_____Work #:_____ Cell #: _____
Occupation:_____Employer: _____
Social Security #:_____ Age:_____ Date of Birth: _____
E-mail Address:_____ Ok to contact by email? _____

Please check the box that applies: [ ] Single [ ] Divorced [ ] Married [ ] Widowed
Name of Spouse/Partner:_____Phone:_____
Nearest Relative or Contact Person:_____ Phone: _____

Have you received chiropractic care in the past? YES / NO When?_____
If yes, please give name of the Chiropractor:_____
Please describe the reason for previous care:_____
Has any adult in your family seen a Chiropractor? YES / NO Has any child in your family seen a Chiropractor? YES / NO

**Please provide a copy of your Insurance card(s)**

Insurance Company:_____ Insurance ID#:_____
Insured Name:_____ Insured Date of Birth:_____

## Patient Condition

Reason(s) for visit:_____

Is this condition due to an accident? YES / NO ☐Auto ☐Work ☐Home ☐Other Date: _____

When did your symptoms appear? _____ Is this condition getting worse? YES / NO

How often do you have this problem?_____ Is it constant or does it come and go?_____

Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐None

Activities or movements that are difficult / painful to perform:

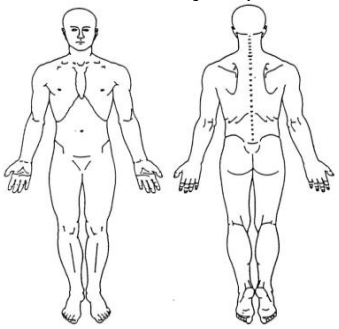
☐ Standing ☐ Sitting ☐ Walking ☐ Lying Down ☐ Bending

What treatment have you already received for your condition?

☐ Medications (Prescribed and over the counter) ☐ Physical Therapy ☐ Surgery ☐Chiropractic Care ☐ Ice/Heat
☐ Stretches None ☐

Name of other doctor(s) who have treated you for this condition:_____

**Body Diagram Instructions:** On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.



**Please rate your pain: 0(no pain) to 10(worst pain)**_____

## Personal Health History

Are you currently under the care of a Healthcare Provider or any other Doctor? YES / NO

If yes, for what condition(s): _____
_____

Provider's Name:_____ Phone:_____

Date of Last: Chiropractic Exam _____ Spinal X-Ray _____ Cholesterol _____
Prostate/PSA _____ Mammogram _____ Pap Smear _____
Stool check for blood _____ Colonoscopy _____ MRI/CT-Scan _____

Place an "X" to indicate if you have had any of the following:

| | | | |
|---|---|---|---|
| Headaches | Irritable Bowel Syndrome | Difficulty Walking | Frequent Infections |
| Sinus Problems | Liver Trouble/Hepatitis | Skin Problems | Ankle/Foot Pain |
| Dizziness | Kidney Problems | Easy Bruising | Sciatica |
| Neck Pain | Difficulty Urinating | Anxiety | Scoliosis |
| Thyroid Problems | Prostate Problems | Depression | Hip/Leg Problems |
| Shoulder/Arm Problems | Menstrual Problems | Unexplained Fatigue | Fainting |
| Ear Problems | Pelvic Pain | Jaw Problems | ADD/ADHD |
| Asthma | Heart Problems | Arthritis | Seizures/Convulsions |
| Throat Problems | Poor Circulation | Chronic Cough/Cold | Orthopedic Issues |
| Difficulty Breathing | Digestive Issues | Osteoporosis | Growing Pains |
| Mid Back/Rib Pain | Colon Trouble | Diabetes Type I or II | Muscle Pain |
| Chest Pain | Diverticulitis | High Blood Pressure | Ruptures/Hernia |
| Wrist/Elbow/Hand Pain | Stroke | Cancer | Anemia |
| Low Back Pain | Knee Pain | Glasses/Contacts | |
| Joint Problems | Poor Posture | Scoliosis | |

Have you sustained an injury playing organized sports? _____

Other health issues, please specify: _____

## Women's Health

Are you pregnant? YES / NO Due Date:_____ Pregnancies #_____ Live Births #_____ Miscarriages #_____

Are you nursing? YES / NO Do you have breast implants? YES / NO Do you have menstrual problems? YES / NO

| Injuries / Surgeries you have had: | Description | Date/Year |
|---|---|---|
| Falls/Injuries | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |
| Car Accidents | | |

## Family History

| Relation | Living | Deceased | Age (now or at death) | Serious Illnesses / Cause of Death |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Sister(s) | | | | |
| Brother(s) | | | | |
| Daughter(s) | | | | |
| Son(s) | | | | |

## Social History

| Exercise | Diet | Work Activity | Habits Now or in the Past | |
|---|---|---|---|---|
| ☐None | ☐Good | ☐Sitting | ☐Smoking | Packs/Day:_____ |
| ☐Infrequent | ☐Fair | ☐Standing | ☐Alcohol | Amount: _____ |
| ☐Occasional | ☐Poor | ☐Lifting | ☐Drugs | Amount :_____ |
| ☐Regular | | ☐Heavy Labor | ☐Coffee/Caffeine Drinks | Cups/Day:_____ |
| | | | ☐High Stress Level | Reason: _____ |

Do you have any concerns about your sexual health? YES / NO
Are you or have you been the victim of domestic or sexual abuse? YES / NO
Are you satisfied with your weight? YES / NO
Have you gained or lost 10lbs in the past 6 months without wanting to? YES / NO
Are you on any special diet? YES / NO
If yes, please describe: _____
How many 8oz glasses of water do you drink a day? _____

## Review

How would you rate your general health? (Mark an "X" where you feel you are) Poor I----------I Excellent

What are your health goals? _____

_____

_____

**Talk to your doctor about other areas that might be affecting your health— such as worries about finances, social support, alcohol, tobacco and/or drug use. Although we work closely to resolve your chief complaint, as health care professionals we are concerned with your overall wellness. On future visits we will discuss issues with you that may impact your overall health.**

## AUTHORIZATION FOR ACUPUNCTURE LASER/NEEDLES

I hereby authorize the Doctor to work with my condition through the use of acupuncture to my body, as he or she deems appropriate. The Doctor will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. If the Doctor does accept my case, it does not guarantee nor does it imply a guarantee of being able to cure or prevent any condition illness or injury. 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, any fees for professional services rendered me will become immediately due and payable.

Patient's signature Date Guardian or Spouse's Signature

## AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I attest that all the answers I have given are correct, to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at Leingang Chiropractic and Wellness at this time. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Patient's signature Date Guardian or Spouse's Signature

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for 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.

**Vertebral Subluxation** is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

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 to the spine.

**Health** is a state of optimal physical, mental and social well being, not merely the absence of disease. 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 subluxation.

I, _____have read and fully understand the above statement. Any 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.

Patient's signature_____Date_____Witness_____

## NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name(Print):_____ Relationship to Patient:_____

Signature:_____ Date:_____