# LAKELAND CHIROPRACTIC CENTER

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P.O. Box 156
2969 Route 23 South
Newfoundland, NJ 07435
Telephone: (973) 697-2455
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## CHIROPRACTIC CASE HISTORY

NAME _____ _____ _____
LAST FIRST MIDDLE INITIAL

DATE _____ DATE OF BIRTH _____ AGE_____

ADDRESS _____

PHONE NUMBER (H)_____(W)_____(C)_____

E-MAIL_____REFERRED BY_____

SOCIAL SECURITY NUMBER_____

CHIEF COMPLAINT: _____

_____

HOW DOES THIS INTERFERE WITH YOUR DAILY LIVING?_____

_____

HOW AND WHEN DID THIS HAPPEN? _____

_____

HAVE YOU HAD THIS BEFORE?_____

ADDITIONAL COMPLAINTS: _____

_____

## [ SOCIAL HISTORY ]

MARRIED ( ) SINGLE ( ) DIVORCED ( ) WIDOW (ER) ( )
SIGNIFICANT OTHER ( ) -- GENDER: ( M) OR (F)

OCCUPATION _____HOW LONG_____

HOBBIES _____

SPORTS _____

EXERCISE _____

TOBACCO USE ____ (CURRENT OR PAST SIX MONTHS)
CIGARETTES ____CIGARS_____ PIPE_____CHEWING___

RECREATIONAL DRUGS_____ ALCOHOL_____
MEDICATION (S)_____

[ FAMILY HISTORY ]

PARENT HEALTH _____ OR CAUSE OF DEATH & AGE _____

SIBLINGS HEALTH _____ OR CAUSE OF DEATH & AGE_____

CHILDRENS HEALTH _____ OR CAUSE OF DEATH &AGE_____

[ PERSONAL HISTORY ]

PAST TRAUMA (EX): FRACTURE, STROKE, DIFFICULT BIRTH _____

_____

SURGERY: _____
_____

TREATMENTS / PROCEDURES_____

_____

ILLNESSES / DISEASES / ALLERGIES_____

HOSPITALIZATIONS_____

ENVIRONMENTAL HAZARD EXPOSURE_____

CANCER _____NIGHT PAIN_____HISTORY OF FALLS_____

EYEGLASSES ____ CONTACTS_____BOWL / URINE DIFFICULTIES_____

DIZZINESS_____ WEIGHT LOSS OR GAIN_____HOURS SLEEPING_____

PATIENT SIGNATURE_____

OR PARENT / GUARDIAN_____

Patient Name: _____

## Activities of Daily Living

For each of the following activities please place a check in the column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

| Activity | Doesn't Hurt at All | Hurts a little | Hurts Very Much | Almost Unbearable | Unbearable Pain, Prevents Activity |
|---|---|---|---|---|---|
| 1. Walking | | | | | |
| 2. Sitting | | | | | |
| 3. Bending | | | | | |
| 4. Standing | | | | | |
| 5. Sleeping | | | | | |
| 6. Lifting | | | | | |
| 7. Running / jogging | | | | | |
| 8. Climbing Stairs | | | | | |
| 9. Carrying | | | | | |
| 10. Pushing / pulling | | | | | |
| 11. Driving | | | | | |
| 12. Dressing | | | | | |
| 13. Reading | | | | | |
| 14. Watching TV | | | | | |
| 15. Household chores | | | | | |
| 16. Gardening | | | | | |
| 17. Sports | | | | | |
| 18. Employment | | | | | |

| Additional Comments: |
|---|
| |
| |

Patient Signature _____ Date _____

Examiner _____ Date _____

Score _____ [72]

Turner JA, Robinson, McCreary CP. Chronic low back pain: Predicting response to non-surgical treatment. *Arch Phys Med Rehabilitation* 1983;64;560-563

# Authorization for Signature on File

Name of Patient:_____ Beneficiary #:_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

_____ _____
Signature Date

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

_____ _____
Signature Date

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# PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
   a) A postcard mailed to me at the address provided by me; and
   b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for *seven years*. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative* Relationship

Date Signed ____/____/____ Witness: _____

*Attorney-In-Fact, Guardian, Parent if a minor