Life Chiropractic

Name: _____ Employer: _____
Address: _____ Address: _____
City/State: _____ City/State: _____
Zip Code: _____ Zip Code: _____
Home Phone #: ( )_____-_____ Work Phone: ( )_____-_____ Extension___
Cell Phone #:( ) _____-_____ Email:_____
Social Security #: _____ Driver's License #:_____ Age:____
Date of Birth: _____ Single_____ Married_____ Other_____

Contact in case of Emergency: Name: _____Relationship:_____
Address: _____
Phone #: ( )_____-_____

Health problem for which you came to this office: _____
Is condition related to: (Please Circle) Employment Auto Accident Other_____
Date Symptoms first occurred: _____
Have you ever had same or similar symptoms? **N** or **Y** Date:_____
Lost work time: **N** or **Y** Date returned to work: _____
Other Doctors you have seen for this problem: _____
Were you Hospitalized? **N** or **Y** If so, where: _____
Have you received Chiropractic care before? **N** or **Y** If so, where: _____

How did you hear about our office?
Insurance_____ TV____ Sign_____ Lecture_____ Website_____ Other_____
Personal referral(name) _____

Primary Physician's Name: _____

PLEASE READ, SIGN AND DATE

I authorize Life Chiropractic to bill my insurance company for charges incurred.
I authorize Life Chiropractic to release medical information requested by the insurance company with regard to my claims filed on my behalf.
I understand that I will be responsible for charges denied by my insurance company.

Signature_____ Date_____

CONFIDENTIAL HEALTH HISTORY

Instructions

- ***Place a _C_ for problems you are experiencing CURRENTLY.***
- ***Place a _P_ for problems you have experienced in the PAST.***
- ***Leave BLANK if you have never experienced the problem now or in the past.***

GENERAL
___Fever
___Chills
___Night Sweats
___Loss of Sleep
___Fatigue
___Nervousness
___Weight Loss or Gain
___Allergies
___Bleeding Problem
___Anemia
___Diabetes
___Cancer
___Thyroid Disease/Goiter
___Alcoholism
___Drug Abuse
___Any Surgeries
___Any Medications
___Any Supplements/Vitamins

EYE EAR NOSE THROAT
___Poor Vision
___Pain in Eyes
___Deafness
___Nose Bleeds
___Sinus Troubles
___Dental Problems
___Hoarseness
___Tonsillectomy

GASTROINTESTINAL
___Poor Appetite
___Difficulty swallowing
___Belching or Gas
___Frequent Nausea
___Vomiting
___Vomiting Blood
___Pain over Abdomen
___Ulcer
___Black or Bloody Stool
___Liver Problems
___Gall Bladder Problems
___Jaundice
___Hernia
___Diarrhea
___Constipation
___Hemorrhoids
___Appendicitis

RESPIRATORY
___Difficulty breathing
___Chronic breathing
___Spitting Phlegm
___Spitting Blood
___Wheezing Asthma
___Pneumonia
___Tuberculosis

CARDIOVASCULAR
___Stroke
___Irregular Heartbeat
___High Blood Pressure
___Pain Over Heart
___Ankle Swelling
___Varicose Veins
___Rheumatic Fever

GENITOUNIARY
___Frequent Urination
___Painful Urination
___Blood in Urine
___Kidney disease
___Inability to control urination
___Difficulty starting urine flow
___Get up _____times per night to urinate
___Breast Lump or Pain
___ STD
___ Sexual Difficulties

WOMEN ONLY
___Hot Flashes
___Painful Periods
___Excessive Flow
___Irregular Cycle
___Vaginal burning or itching
___Date Last Period Began
___Date of Last Pap test

MEN ONLY
___Testicular swelling
___Prostate Problems

NEUROLOGIC
___Weakness
___Twitching
___Tremors
___Headache
___Fainting
___Dizziness
___Convulsions
___Epilepsy
___Numbness/tingling
___Arm/Leg pain
___Mental Disorder

SKIN
___Itching
___Bruising easily
___Skin Cancer
___Change in Mole

MUSCULOSKETAL
___Neck Stiffness/Pain
___Pain Between Shoulders
___Low Back Pain
___Swollen Joints
___Painful Joints
___Muscle Aches/Soreness
___Spinal Curvature
___Arthritis
___Any Fractures

HABITS
___Drinking
___Smoking
___packs per day
___Recreational Drug Use

EXERCISE
___None
___1-2 times per week
___3-5 times per week
___6-7 times per week

FAMILY HISTORY
___Muscle, bone or nerve
___Diabetes
___Thyroid Disease
___Tuberculosis
___High Blood Pressure
___Heart Disease
___Kidney Disease
___Cancer

Name: **Date:_____/_____/_____**

Consent for Chiropractic Treatment and Acknowledgment of Receipt of Information

To the patient: Every type of health care is associated with some risk of a potential problem. Health care providers, including chiropractors, are required by law, to tell you the nature of your condition, the general nature of the treatment, the risks involved, and the reasonable therapeutic alternatives.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. Please read this form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although our occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

1) Stroke: Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). This problem occurs so rarely that there is no conclusive data to quantify probability.
2) Disc herniations: Disc herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem, resulting in increased low back pain, and numbness of a transient nature. Residual may last for a few days but seldom for longer periods of time.
3) Soft tissue injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long-term affects for the patient.
4) Rib fractures: The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

----------CONSENT----------

I hereby authorize and direct Dr. Rehkopf, together with associates and assistants of his choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/ adjustment, various modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

Patient's name_____ Date_____ Time_____

Signature of patient, parent or guardian _____

Relationship to patient _____

I certify that I have provided and explained the information set forth herein, including any attachments, and have answered all questions concerning proposed treatment to the best of my knowledge and ability.

Signature of Chiropractic physician_____**Date**_____**Time**_____