Lumina Chiropractic

Name: _____ Date: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

E-mail: _____ SS#: _____

Marital Status: M S D W Occupation: _____

Emergency Contact Name & Phone #: _____

How did you find out about our office? _____

Name of Primary Doctor of Medicine/Clinic: _____

Name of Previous Doctor of Chiropractic/Clinic: _____

Approximate date of last visit to chiropractor: _____

Name of Insurance Company (if applicable) _____

I hereby authorize Lumina Chiropractic to administer examination or treatment as is necessary and certify no guarantees or assurances have been made to me as to the results that may be obtained. _____
Initial Here

I give permission to Lumina Chiropractic to treat me in an open treatment area where other patients may overhear some of my protected health information, and I acknowledge that I can speak with the doctor in a private room at any time at my request. _____
Initial Here

I authorize Lumina Chiropractic to provide my insurance company with a report of my physical examination, diagnosis, treatment, prognosis, etc. in regard to my treatment if requested by them. I authorize and direct payment to Lumina Chiropractic any sums that may be due for chiropractic services rendered to me. I understand that my insurance policy is a contract between myself and my insurance company, and that I am fully responsible to Lumina Chiropractic for all bills submitted for services rendered. I have read and agree to be bound by the terms of this assignment of health insurance benefits. _____
Initial Here

Health Information Privacy Notice: All healthcare providers are required by law to advise you of how their office will use your protected health information. The entire notice is displayed in our reception area for your review, if you choose to read it in its entirety. Nothing in this notice will change the way we provide care, obtain payment, or run our office. Please read the Health Information Privacy Notice and initial, stating that you have been made aware of this Federal Health Information Policy. _____
Initial Here

_____

Patient's Signature (or legal guardian) Date

Phone (910) 256-2655 Fax: (910) 256-2358 www.luminachiropractic.com

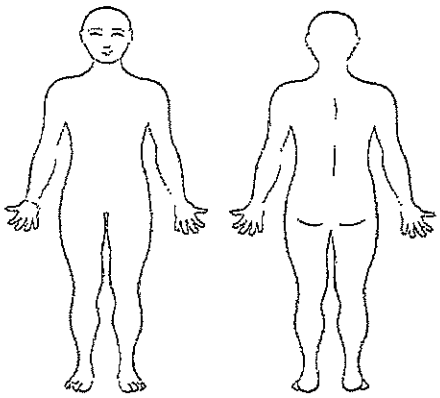
Lumina Chiropractic Patient Health Questionnaire

Patient Name_____ Date_____

1. Describe your symptoms, when you first noticed them, and how they began:

Symptom	When first noticed	How symptom began
1)		
2)		
3)		

2. How often do you experience your symptoms?
   - o Constantly (76-100% of the day)
   - o Frequently (51-75% of the day)
   - o Occasionally (26-50% of the day)
   - o Intermittently (0-25% of the day)



Indicate where your symptoms occur on the body diagram

3. Describe the timing of your symptoms?
   - o Worse in the morning
   - o Worse at the end of the day
   - o Worse at night
   - o The same throughout the day

4. What describes the nature of your symptoms?

Sharp Dull Aching Burning Shooting Throbbing Numb Tingling

5. Do your symptoms radiate into any of the following areas? Please Circle: LEFT | RIGHT | BOTH

Shoulder			Arm			Elbows			Hands			Buttocks			Legs			Knees			Feet		
L	R	B	L	R	B	L	R	B	L	R	B	L	R	B	L	R	B	L	R	B	L	R	B

6. How are your symptoms changing since they began?

Getting Better Not Changing Getting Worse

7. On a scale of 1-10, how would you rate your symptoms at their worst? (1 being "no pain" and 10 being "Unbearable pain")

1(no pain)	2	3	4	5	6	7	8	9	10(unbearable pain)

8. Who else have you seen for your symptoms?

Medical Doctor Other Chiropractor Physical Therapist No One

9. Circle all activities that aggravate your condition/symptoms:

Sitting Standing Walking Bending Stooping Stooping Lifting Sleeping Lying Down
Movement Sneezing Coughing Straining Reaching Twisting Rest Driving Typing
Computer Use Exercise Household Chores Looking Up Looking Down

10. Height _____ ft._____ in. Weight: _____ Patient Initials: _____

11. For each condition below, place a check mark in the "Past" column if you've had it in the past, and place a check mark in the "Present" column if you currently have it.

	Past	Present			Past	Present
Headaches				High Blood Pressure		
Neck Pain				Heart Attack		
Upper Back Pain				Chest Pains/Angina		
Mid Back Pain				Stroke		
Low Back Pain				Kidney Stones		
Shoulder Pain				Bladder Infection		
Elbow Pain				Loss of Bladder Control		
Wrist Pain				Prostate Problems		
Hand Pain				Abnormal Weight Loss		
Hip Pain				Loss of Appetite		
Knee Pain				Abdominal Pain		
Ankle Pain				Ulcers		
Foot Pain				Indigestion/Reflux		
Jaw Pain				Asthma		
Fatigue				Sinusitis		
Dizziness				Allergies		
Vertigo				Diabetes		
Sinus Pain				Depression		
Arthritis				Cancer/Tumor		

12. Females Only:

	Past	Present
Pregnancy		
Birth Control		
Hormone Replacement		

13. Indicate if an immediate family member has had any of the following:

	Mother	Father	Aunt	Uncle	Sister	Brother
Rheumatoid Arthritis						
Heart Problems						
Diabetes						
Cancer						
Lupus						
Other						

14. List all prescriptions and over-the-counter medications you are taking:

_____

15. List all surgical procedures you have had and/or any times you have been hospitalized:

_____

Patient Signature:_____ Date:_____

Lumina Chiropractic, PA

INFORMED CONSENT FORM

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ spinal manipulative therapy	___ palpation	___ vital signs
___ range of motion testing	___ orthopedic testing	___ basic neurological testing
___ muscle strength testing	___ postural analysis	___ Laser Therapy
___ ultrasound	___ hot/cold therapy	___ Electrical Stim
___ radiographic studies	___ mechanical traction	___ Decompression Therapy
___ Massage Therapy	Other (please explain) _____	

_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Brian Heer or Dr. Ashly Smith and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ Dated: _____

_____ _____
Patient's Name Doctor's Name

_____ _____
Signature Doctor's Signature

_____
Signature of Parent or Guardian
(if a minor)

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