

Lynch Clinic of Chiropractic, P.C
1410 Incarnation Drive, Suite 202C
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NEW PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your Driver's License and Insurance card(s) (if applicable).

PLEASE PRINT CLEARLY.

Full Name: _____ Gender: M F Age: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security#: _____ - _____ - _____ E-mail: _____ Home Phone: (____) _____
Marital Status: S M D W # of Children: _____ Work Status: Full time Part-time Retired Cell: (____) _____
Females: Last Menstrual Period: _____ Pregnant? Y N Nursing? Y N Fax: (____) _____
Employer: _____ Occupation: _____ Work Phone: (____) _____
Employer Address: _____ City: _____ State: _____ Zip: _____

Name of Spouse, Parent or Guardian: _____ Age: _____ Birth Date: _____ SS#: _____ - _____ - _____
Spouse's Employer: _____ Spouse's Occupation: _____ Work Phone: (____) _____
In case of an Emergency Contact: _____ Relationship: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
Do you have Medicare Insurance? Y N Medicare card copied by Office Staff
 Drivers license copied by Office Staff

Who may we thank for referring you? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Lynch Clinic of Chiropractic, P.C. to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Lynch Clinic of Chiropractic, P.C. to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature: _____ Date: _____

Spouse's or Guardian's Signature: _____ Date: _____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

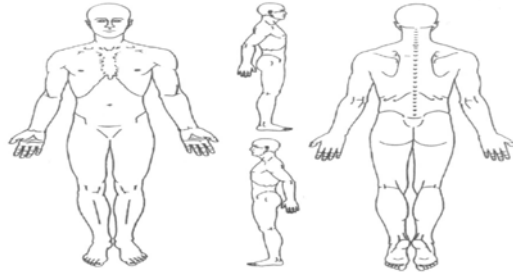
- 1) _____
- 2) _____
- 3) _____
- 4) _____

TREATMENT: What type of treatment are you looking for?

- I am looking for the most minimal amount of care to “patch up the symptoms” of my problem.
 I am looking to resolve my symptoms and then go on to “fix the cause” of my problem.
 I am looking to take care of my problem and then go on to “achieve optimal health and wellness.”

Please mark on the diagram to the right the following symbols as they relate to the patients' symptoms:

- | | |
|--------------------|-----------------|
| SS = spasms | ST = stiffness |
| DP = dull pain | SP = sharp pain |
| SH = shooting pain | TI = tingling |
| NU = numbness | O = Other |



COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: Y N

Whom? MD DO DC DDS Other: _____ Name of primary doctor? _____

Treatment(s) Tried: Medication Surgery Lifestyle change Chiropractic other _____

Have you had any intolerance or reactions to treatments? Y N Describe: _____

When did the problem start?: _____ How did it originally occur? _____

Has it become worse recently? Y N Same Better Gradually worse How frequent is the condition? Constant Daily Intermittent

How long does it last? All day Few hours Minutes Is this condition interfering with your? Work Sleep Daily routine Recreation

Does anything relieve the symptom(s)? Y N Medication(prescription or OTC) Rest Exercise/Stretch Other: _____

If no, what have you tried? Medication (prescription or OTC) Rest Exercise/Stretch Surgery

Is there anything that you can do to relieve the symptom? Y N Medication(prescription or OTC) Rest Exercise/Stretch Other: _____

If no, what have you tried to do that has not helped? Medication (prescription or OTC) Rest Exercise/Stretch Surgery Chiropractic

Other: _____

How long has it been since you really felt good? Days Weeks Months Years >10 years

Describe the pain/problem: Sharp Dull Numbness Tingling Aching Burning Stabbing Other: _____

What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other: _____

What do you believe is cause of the problem? _____

Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? _____

Please check all of the symptoms that apply. (P=Past / C= Current)

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> <input type="checkbox"/> P / C Headache | <input type="checkbox"/> <input type="checkbox"/> P / C High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> P / C Tingling in Feet | <input type="checkbox"/> <input type="checkbox"/> P / C Facial Pain | <input type="checkbox"/> <input type="checkbox"/> P / C Low Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> P / C Walking Problems | <input type="checkbox"/> <input type="checkbox"/> P / C Eye Pain | <input type="checkbox"/> <input type="checkbox"/> P / C Abdominal Pains | <input type="checkbox"/> <input type="checkbox"/> P / C Sore Muscles | <input type="checkbox"/> <input type="checkbox"/> P / C Blurred Vision |
| <input type="checkbox"/> <input type="checkbox"/> P / C Nausea/Vomiting | <input type="checkbox"/> <input type="checkbox"/> P / C Weak Muscles | <input type="checkbox"/> <input type="checkbox"/> P / C Dizziness | <input type="checkbox"/> <input type="checkbox"/> P / C Poor Appetite | <input type="checkbox"/> <input type="checkbox"/> P / C Paralysis |
| <input type="checkbox"/> <input type="checkbox"/> P / C Earache | <input type="checkbox"/> <input type="checkbox"/> P / C Fullness of Bladder | <input type="checkbox"/> <input type="checkbox"/> P / C Shakiness | <input type="checkbox"/> <input type="checkbox"/> P / C Forgetfulness | <input type="checkbox"/> <input type="checkbox"/> P / C Urination Difficulty |
| <input type="checkbox"/> <input type="checkbox"/> P / C Sweating | <input type="checkbox"/> <input type="checkbox"/> P / C Confusion | <input type="checkbox"/> <input type="checkbox"/> P / C Frequent Urination | <input type="checkbox"/> <input type="checkbox"/> P / C Insomnia | <input type="checkbox"/> <input type="checkbox"/> P / C Sinusitis |
| <input type="checkbox"/> <input type="checkbox"/> P / C Constipation | <input type="checkbox"/> <input type="checkbox"/> P / C Fainting | <input type="checkbox"/> <input type="checkbox"/> P / C Teeth Grinding | <input type="checkbox"/> <input type="checkbox"/> P / C Hemorrhoids | <input type="checkbox"/> <input type="checkbox"/> P / C Convulsions |
| <input type="checkbox"/> <input type="checkbox"/> P / C Dry Mouth | <input type="checkbox"/> <input type="checkbox"/> P / C Decreased Sex Drive | <input type="checkbox"/> <input type="checkbox"/> P / C Irritability | <input type="checkbox"/> <input type="checkbox"/> P / C Excessive Thirst | <input type="checkbox"/> <input type="checkbox"/> P / C Menstrual Irregularities |
| <input type="checkbox"/> <input type="checkbox"/> P / C Impatience | <input type="checkbox"/> <input type="checkbox"/> P / C Unpleasant Taste | <input type="checkbox"/> <input type="checkbox"/> P / C Elbow / Hand Pain | <input type="checkbox"/> <input type="checkbox"/> P / C Fatigue | <input type="checkbox"/> <input type="checkbox"/> P / C Neck Pain |
| <input type="checkbox"/> <input type="checkbox"/> P / C Tingling in Hands | <input type="checkbox"/> <input type="checkbox"/> P / C Feel Loss of Control | <input type="checkbox"/> <input type="checkbox"/> P / C Sore Throat | <input type="checkbox"/> <input type="checkbox"/> P / C Clammy Hands | <input type="checkbox"/> <input type="checkbox"/> P / C Lump in Throat |
| <input type="checkbox"/> <input type="checkbox"/> P / C Low Back Pain | <input type="checkbox"/> <input type="checkbox"/> P / C Swallowing Pain | <input type="checkbox"/> <input type="checkbox"/> P / C Hip Pain | <input type="checkbox"/> <input type="checkbox"/> P / C Unsteady Voice | <input type="checkbox"/> <input type="checkbox"/> P / C Knee Pain |
| <input type="checkbox"/> <input type="checkbox"/> P / C Shoulder Pain | <input type="checkbox"/> <input type="checkbox"/> P / C Poor Circulation | <input type="checkbox"/> <input type="checkbox"/> P / C Persistent Coughing | <input type="checkbox"/> <input type="checkbox"/> P / C Swollen Joints | <input type="checkbox"/> <input type="checkbox"/> P / C Chest Pressure |
| <input type="checkbox"/> <input type="checkbox"/> P / C Joint Stiffness | <input type="checkbox"/> <input type="checkbox"/> P / C Slow Heart Rate | <input type="checkbox"/> <input type="checkbox"/> P / C Swollen Ankles | <input type="checkbox"/> <input type="checkbox"/> P / C Rapid Heart Rate | <input type="checkbox"/> <input type="checkbox"/> P / C Ankle / Foot Pain |
| <input type="checkbox"/> <input type="checkbox"/> P / C Other: _____ | | | | |

Patients Name: _____ Date: _____

ALLERGIES/Sensitivities: Please check and list all allergies.

- Food: Dairy Wheat Corn Soy Seafood Gluten Peanuts Fruits Other: _____
- Medications: Penicillin Sulfa Drugs Iodine Insulin Antibiotics Other: _____
- Seasonal/Other: Pollen Dust Hay Mold Chemical(s) Smoke Animals Insects Other: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	<u>Medication Name</u>	<u>Date Started</u>
<input type="checkbox"/> Antacids		
<input type="checkbox"/> Antibiotics		
<input type="checkbox"/> Antidepressants		
<input type="checkbox"/> Anti-Diabetics		
<input type="checkbox"/> Anti-Inflammatory		
<input type="checkbox"/> Blood Pressure Lowering Meds.		
<input type="checkbox"/> Cholesterol Lowering Meds.		
<input type="checkbox"/> Hormone Replacements (HRT)		
<input type="checkbox"/> Oral Contraceptives		
<input type="checkbox"/> OTC (over the counter) Other		

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? Y N If yes, who recommended them? _____

SCARS / SURGICAL PROCEDURES: Have you had any surgical procedures? YES NO Any Scars? YES NO

SPINE: Cervical Thoracic Lumbar EXTREMITIES: Shoulder/Elbow/Hand/Wrist R L Hip/Knee/Ankle/Foot R L

ABDOMINAL/CHEST: Appendix Colon Gall Bladder Heart Lungs Breast Other: _____

HABITS:

	Heavy	Moderate	Light	None	5-7x/wk	3-5x/wk	1-3x/wk	None	Type
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Aerobic <input type="checkbox"/> Weights
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs
Soda / Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5+	4	3	2	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	64+ oz	32-64 oz	16-32 oz	<8 oz	
					Water / day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WORK ACTIVITY: Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking / Moving Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(F = Family, P = Personal History)

- | | | | |
|--------------------------|-------------------|---------------------|------------------|
| ___ Alcoholism | ___ Eczema | ___ Miscarriage(s) | ___ Tumor(s) |
| ___ Anemia | ___ Emphysema | ___ Mumps | ___ Ulcer(s) |
| ___ Cancer | ___ Epilepsy | ___ Pleurisy | ___ Other: _____ |
| ___ Cold sores | ___ Goiter | ___ Pneumonia | _____ |
| ___ Deep vein thrombosis | ___ Gout | ___ Polio | _____ |
| ___ Detached retina | ___ Heart disease | ___ Rheumatic fever | |
| ___ Diabetes | ___ HIV / AIDS | ___ Stroke | |

Patient's Printed Name

Patient's Signature

Date

Reviewed By: _____ Date: _____