LAKESHORE FAMILY CHIROPRACTIC

Dr Blake Spooner & Associates
258 James St., Suite 10 Holland, MI 49424
Phone: (616) 396-6635 Fax: (616) 396-6679

Name:_____ Gender: _____ Date:_____
Address: _____ City/State: _____ Zip: _____
Home Phone: _____ Cell or Work Phone:_____
Email: _____Date of Birth: _____ Age: _____
Employer: _____ Occupation:_____
Spouse's Name: _____ Spouse's Occupation: _____
Primary Medical Doctor: _____Social Security Number:_____

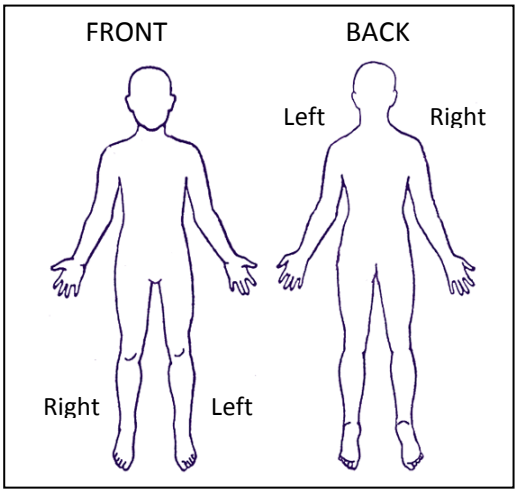
PRIMARY REASON FOR CONSULTING OUR OFFICE

Please list complaints in order of priority.

1. Primary complaint_____

Reason for today's visit: ❒ Emergency ❒ New Injury ❒ Old injury ❒ Chronic Pain ❒ No complaints /Wellness
Pain or problem started on_____ Onset of problem was: ❒ Gradual ❒ Sudden
Is this due to: ❒ Auto ❒ Work ❒ Sports/play ❒ Routine/Household activity ❒ Other Explain _____
Frequency of problem: ❒ 10% ❒ 20% ❒ 30% ❒ 40% ❒ 50% ❒ 60% ❒ 70% ❒ 80% ❒ 90% ❒ 100%
Have you ever had the same or similar condition? ❒ Yes ❒ No Explain _____
On a scale of 0 to 10, how would you rate your pain/symptoms today?
(Identify by putting a O around the level of pain today, a ☐ around the level of pain at its best, and a Δ at its worst)
None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible
Is this condition worse at certain times of the day? ❒ Morning ❒ Afternoon ❒ Evening ❒ During sleep
This condition is getting: ❒ Better ❒ Worse ❒ Staying the same - This condition is: ❒ Constant ❒ Comes and goes
What makes the problem worse? ❒ Standing ❒ Sitting ❒ Lying ❒ Bending ❒ Lifting ❒ Twisting
❒ Other _____
Is there anything you can do to relieve the problem?
❒ Yes, describe:_____
❒ No, what have you tried to do that has not helped?_____
_____
Describe the pain: ❒ Sharp ❒ Dull ❒ Numbness ❒ Tingling
❒ Aching ❒ Burning ❒ Stabbing ❒ Other_____
RATE YOUR PAIN: Place an "X" on the drawings wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:
(By listing XST on the low back means you have stabbing pain on your low back)

A = Ache **B = Burning** **ST = Stabbing**
SP = Spasm **N = Numbness** **P = Pins and Needles**
T = Throbbing



2. Secondary complaint

_____
Pain or problem started on_____ Onset of problem was: ❒ Gradual ❒ Sudden
Frequency of problem: ❒ 10% ❒ 20% ❒ 30% ❒ 40% ❒ 50% ❒ 60% ❒ 70% ❒ 80% ❒ 90% ❒ 100%
On a scale of 0 to 10, how would you rate your pain/symptoms today?
(Identify by putting a O around the level of pain today, a ☐ around the level of pain at its best, and a Δ at its worst)
None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

3. Tertiary complaint _____
Pain or problem started on_____ Onset of problem was: ❒ Gradual ❒ Sudden
Frequency of problem: ❒ 10% ❒ 20% ❒ 30% ❒ 40% ❒ 50% ❒ 60% ❒ 70% ❒ 80% ❒ 90% ❒ 100%
On a scale of 0 to 10, how would you rate your pain/symptoms today?
(Identify by putting a O around the level of pain today, a ☐ around the level of pain at its best, and a Δ at its worst)
None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible
Have you been under medical care recently or for this problem(s)? ❒ Yes ❒ No

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HEALTH HISTORY

Now Have / In the Past / Family History

- ❍ ❒ △ Fractured/broken bones
- ❍ ❒ △ Auto accidents
  - _____ 0-5 years
  - _____ over 5 years
- ❍ ❒ △ Other accident or falls
- ❍ ❒ △ Back curvature
- ❍ ❒ △ Arthritis
- ❍ ❒ △ Diabetes
- ❍ ❒ △ Cancer
- ❍ ❒ △ Learning disability
- ❍ ❒ △ Eating disorder

Now Have / In the Past / Family History

- ❍ ❒ △ Trouble Sleeping
  - _____ Stomach sleeper
  - _____ Side sleeper
  - _____ Back sleeper
- ❍ ❒ △ Numbness / tingling
  - _____ Hand / Fingers
  - _____ Arms
  - _____ Legs
  - _____ Feet / Toes
  - _____ Buttocks
  - _____ Head or face

Now Have / In the Past / Family History

- ❍ ❒ △ Muscle Spasms
- ❍ ❒ △ Neck pain/stiffness
- ❍ ❒ △ Shoulder pain / Arm pain
- ❍ ❒ △ Upper back pain/stiffness
- ❍ ❒ △ Mid back pain/stiffness
- ❍ ❒ △ Low back pain/stiffness
- ❍ ❒ △ Hip pain
- ❍ ❒ △ Swollen/painful joints
- ❍ ❒ △ Hepatitis
- ❍ ❒ △ Pacemaker
- ❍ ❒ △ Drug /Alcohol addiction

Have you ever had surgery? ❒ Yes ❒ No Explain_____
Do you have allergies of any kind? ❒ Yes ❒ No Explain _____
When did you last see a chiropractor? _____ Dr/Office name:_____
Why did you see this chiropractor?_____Were you helped? ❒ Yes ❒ No
What spinal maintenance programs were you given to follow to maximize the future stability of your spine?
_____
Did you follow it? ❒ Yes ❒ No If not, why _____
If you are changing chiropractors, why are you changing?_____

SOCIAL HISTORY & LIFE CHOICES

Exercise: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never
Alcohol: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never
Drugs: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never
Tobacco: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Caffeine Products: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never
Diet: ❒ Poor ❒ Fair ❒ Good ❒ Excellent
Mental Stress: ❒ Mild ❒ Moderate ❒ Marked

How do you want us to handle your problems? ❒ Maximum Correction (Correct the cause of the problem so it does not return)
❒ Temporary Relief (Help the symptom but do not fix the cause of the problem)

Why did you come to our clinic, and what are your expectations of us?_____
_____

Are your problems affecting your ability to either perform or enjoy work, activities or hobbies? ❒ Yes ❒ No

If your problems go uncorrected and get worse, do you think you will be able to perform or enjoy these activities?
❒ Yes ❒ No

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REVIEW OF SYSTEMS

Mark with an "X" all that apply.

General	❒ None	❒ daytime drowsiness	❒ fever	❒ night sweats
	❒ chills	❒ fatigue	❒ weight gain / loss (circle)	❒ loss of appetite
Eyes/Vision	❒ None	❒ cataracts	❒ itching	❒ tearing
	❒ blindness	❒ double vision	❒ sensitivity to light	
	❒ blind spots	❒ eye problems	❒ wears contacts/glasses	
Ears, Nose & Throat	❒ None	❒ fainting	❒ history of head injury	❒ runny nose
	❒ dizziness	❒ frequent sore throats	❒ loss of sense of smell	❒ sinus infection
	❒ ear discharge	❒ headaches	❒ nosebleeds	❒ ringing in ears
	❒ ear pain	❒ hearing loss	❒ nasal congestion	❒ allergies
Respiration	❒ None	❒ cough	❒ shortness of breath	❒ wheezing
	❒ asthma	❒ coughing up blood	❒ excessive mucus	
Cardiovascular	❒ None	❒ high blood pressure	❒ heart murmur	❒ varicose veins
	❒ leg pain and ache	❒ low blood pressure	❒ palpitations	❒ cold hands/feet
	❒ chest pain	❒ fainting	❒ shortness of breath with exertion	
	❒ heart problem	❒ difficulty breathing lying down		
Gastrointestinal	❒ None	❒ belching	❒ difficulty swallowing	❒ jaundice
	❒ abdominal pain	❒ black tarry stool	❒ heartburn	❒ ulcers
	❒ abnormal stool	❒ constipation	❒ hemorrhoids	❒ rectal bleeding
	(Color/consistency)	❒ diarrhea	❒ loss of bowel control	❒ indigestion
Skin	❒ None	❒ change in skin color	❒ history of skin disorders	❒ rash
	❒ itching	❒ hair loss	❒ change in nail texture	❒ skin lesions/ulcers
	❒ hives	❒ numbness	❒ varicosities	
Nervous System	❒ None	❒ limb weakness	❒ seizures	❒ stroke
	❒ dizziness	❒ loss of consciousness	❒ sleep disturbance	❒ stress
	❒ facial weakness	❒ loss of memory	❒ slurred speech	❒ headache
	❒ numbness	❒ unsteadiness of gait/loss		
Psychological	❒ None	❒ bi-polar disorder	❒ depression	❒ memory loss
	❒ anxiety	❒ confusion	❒ insomnia	❒ mood change
	❒ behavioral change	❒ convulsions	❒ loss or change of appetite	❒ tension/stress
Hematologic	❒ None	❒ bleeding	❒ blood transfusion	❒ fatigue
	❒ blood clotting	❒ lymph node swelling	❒ bruising easily	❒ anemia
Female Only	❒ None/NA	❒ birth control	❒ frequent urination	
	❒ hormone therapy	❒ breast lump/pain	❒ burning urination	
	❒ cramps	❒ vaginal discharge	❒ urine retention/ incontinence	
	❒ I am currently pregnant		❒ I am NOT currently pregnant	
	❒ I currently have a period		❒ I currently do NOT have a period	
	❒ My periods are regular		❒ My periods are NOT regular	
Male Only	❒ None/NA	❒ burning urination	❒ frequent urination	
	❒ erectile dysfunction	❒ hesitancy/dribbling	❒ urine retention/incontinence	

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HIPPA PRIVACY PRACTICES

I acknowledge that Lakeshore Family Chiropractic, PLC "Notice of Privacy Practices" has been made available to me. I understand I have the right to review Lakeshore Family Chiropractic's Notice of Private Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations at Lakeshore Family Chiropractic, PLC.

The Notice of Privacy Practice is also posted on our website at www.lakeshorefamilychiropractic.com. It is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Lakeshore Family Chiropractic, PLC's duties with respect to my protected health information. Lakeshore Family Chiropractic, PLC, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Please list below the names of person(s) authorized to gain access to patient account information:

_____

_____

PRIVACY & COMMUNICATION

In general, the HIPPA privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the patient's office instead of their home. Occasionally our office will send out greeting cards, reminder postcards, call you regarding an appointment, etc. Written communication will be sent to the address specified on your patient intake unless you request otherwise.

I would like Appointment Reminders by:

❒ Text - Cell phone number_____Cell phone provider_____

❒ Phone – number _____

❒ Work phone _____

Email communication: ❒ I give my permission to send occasional emails with birthday gifts, news, specials, and events.
(We will not sell or give your address to third parties)

INFORMED CONSENT

The doctor will use hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

The doctors are aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to my taking a detailed clinical history and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should let us know when we take your clinical history.

_____

Print Name ***Signature*** ***Date***

****

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____

Name Patient Representation (parent, guardian) ***Signature*** ***Date***

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ACKNOWLEDGMENT OF UNDERSTANDING

By signing below, I acknowledge that I have been provided a copy of the Lakeshore Family Chiropractic Clinic Policies and Payment Policy. I have also been notified of the HIPAA Policy and Privacy Practices utilized in this office. Copies are posted on our website at www.lakeshorefamilychiropractic.com. It is also provided upon request at the main administration desk.

I understand that I am financially responsible and agree to pay any health insurance deductibles, co-insurance, co-pays, and amounts not covered by insurance or Medicare. If my account is delinquent, I agree to pay all expenses incurred by this office to collect the account. This includes, but is not limited to, items such as agency fees, court costs, and attorney fees.

My signature also authorizes the payment be made directly to Lakeshore Family Chiropractic for any and all insurance benefits or reimbursements for services rendered by this company as well as authorizes the release of information concerning my health and health care services to my insurance companies, health plan or Medicare.

I understand and agree that Lakeshore Family Chiropractic has the right to refuse to accept me at any time before treatment begins. (A consultation and the conducting of a physical evaluation are not considered treatment.)

I authorize the staff of Lakeshore Family Chiropractic to perform any necessary services needed during diagnosis and treatment. I also certify that no guarantee has been made as to the results that may be attained through such treatment.

I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____

Signature of Patient/ Patient Representation (parent, guardian) ***Date***

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ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with requirements for the government EHR incentive program

Full Name: _____ **DOB:** _____ **Gender**: _____

Preferred Language: ❒ English ❒ Other:_____

Smoking Status (Check one): ❒ Every Day Smoker ❒ Occasional Smoker ❒ Former Smoker ❒ Never Smoked

CMS requires providers to report both race and ethnicity

Race (Check one): ❒ American Indian or Alaska Native ❒ Asian
❒ Black or African American ❒ White (Caucasian)
❒ Native Hawaiian or Pacific Islander ❒ Other
❒ I Decline to Answer

Ethnicity (Check one): ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications) ❒ **None**

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? ❒ **None**

Medication Name	Reaction	Onset Date	Additional Comments

❒ **I choose to decline receipt of my clinical summary after every visit**
(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ ***Date:***_____

For office use only
Height: _____ Weight:_____ Blood Pressure:_____ /_____ Pulse _____