

# Adult Member Health Record

## ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	
AGE:	
SOCIAL SECURITY NUMBER:	GENDER:
MARITAL STATUS: (PLEASE CIRCLE) M / S / W / D	NUMBER OF CHILDREN:
EMPLOYER ADDRESS & CITY	
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD	

## EMERGENCY CONTACT

SPOUSE / SIGNIFICANT OTHER / PARENT (IF MINOR)
TELEPHONE:
EMPLOYER / POSITION:

## HEALTH HABITS

DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK COFFEE, TEA OR SODA? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU EXERCISE REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU WEAR:
<input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS

## MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> INSULIN
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> PAIN KILLERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> OTHER

## HEALTH EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

## REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
PLEASE BRIEFLY DESCRIBE, INCLUDING THE IMPACT IT HAS HAD ON YOUR LIFE. IF YOU'RE ONLY HERE FOR CHIROPRACTIC WELLNESS SERVICES PLEASE SKIP TO NEXT PAGE: <input type="checkbox"/> WELLNESS <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> JOB <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER
PLEASE EXPLAIN IMPACT?
WHEN DID THIS CONCERN BEGIN?
HAS THIS CONCERN: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONCERN INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONCERN OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS: <input type="checkbox"/> GOOD <input type="checkbox"/> BAD <input type="checkbox"/> INDIFFERENT
HOW ARE YOU 'FEELING' TODAY? (CIRCLE BELOW, 1= LOW PAIN 10= UNBELIEVABLE PAIN)
1   2   3   4   5   6   7   8   9   10
HOW OFTEN ARE YOUR SYMPTOMS PRESENT? 0-25%   25-50%   50-75%   75-100% OF THE TIME

### ARE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

### GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.


- Relief care:** Symptomatic relief of pain or discomfort.
- Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
- Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- I want the Doctor to select the type of care for my condition.**

### MEDICATIONS / SUPPLEMENTS

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> BLOOD THINNERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> PAIN KILLERS (INCLUDING ASPIRIN)
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> VITAMINS:
<input type="checkbox"/> INSULIN	<input type="checkbox"/> SUPPLEMENTS:
<input type="checkbox"/> ESSENTIAL FATTY ACIDS	<input type="checkbox"/> PROBIOTIC
<input type="checkbox"/> MULTIVITAMIN	<input type="checkbox"/> VITAMIN C
<input type="checkbox"/> CALCIUM / MAGNESIUM	<input type="checkbox"/> OTHER:

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please **CIRCLE** below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.

### YOUR CONCERNS



Sore Throat Stiff Neck Radiating Arm Pain Hand/Finger Numbness Asthma Allergies High Blood Pressure Heart Conditions	C1	Headaches Migraines Dizziness Sinus Problems Allergies Fatigue Head Colds Vision Problems Difficulty Concentrating Hearing Problems
	C2	
	C5	
	C6	
	C7	
	T2	
	T3	
Constipation Colitis Diarrhea Gas Pain Irritable Bowel Bladder Problems Menstrual Problems Low Back Pain Pain or Numbness in legs Reproductive Problems	T4	Middle Back Pain Congestion Difficulty Breathing Bronchitis Pneumonia Gallbladder Conditions Stomach Problems Ulcers Gastritis Kidney Problems
	T5	
	T6	
	T7	
	T8	
	T9	
	L1	
L2		
L3		
L4		
L5		
S	<b>OTHER:</b>	
A	_____	
C	_____	

### HEALTH CONDITIONS...

**INSTRUCTIONS:** Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> PAIN IN ARMS/LEGS/HANDS	<input type="checkbox"/> NUMBNESS	<b>FOR WOMEN ONLY:</b>	
<input type="checkbox"/> HEART SURGERY/PACEMAKER	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> ALLERGIES	ARE YOU PREGNANT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> LOWER BACK PROBLEMS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> DIABETES	IF YES, WHEN IS YOUR DUE DATE?	
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> SURGERIES:	ARE YOU NURSING?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PAIN BETWEEN SHOULDERS	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> ASTHMA	ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LOSS OF SLEEP	<b>DO YOU:</b>	
<input type="checkbox"/> FREQUENT NECK PAIN	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> DIZZINESS	EXPERIENCE PAINFUL PERIODS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
				HAVE IRREGULAR CYCLES?	<input type="checkbox"/> YES <input type="checkbox"/> NO
				HAVE BREAST IMPLANTS?	<input type="checkbox"/> YES <input type="checkbox"/> NO

SURGERIES/HOSPITALIZATIONS: (PLEASE LIST ALL SURGERIES / HOSPITALIZATIONS YOU HAVE HAD)

### INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

By signing below I agree to the above and allow the doctor, affiliated with Leucadia Chiropractic, to perform such. This consent will cover the entire course of my treatment.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### AUTHORIZATION FOR CARE / ASSIGNMENT OF BENEFITS

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

**Ownership of X-ray Films:** It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

SIGN IF READ ABOVE \_\_\_\_\_ DATE \_\_\_\_\_

### NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description is posted in the reception room of Leucadia Chiropractic for anyone to view. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE:

LEUCADIA CHIROPRACTIC OFFICE FEE SCHEDULE

OFFICE FEE SCHEDULE

Welcome to our office! The information below regarding our fees is provided to you to make you aware that our fees are different if you are a cash paying patient versus if you have insurance, a personal injury (auto accident) or workers compensation case.

**CASH:** Currently, our cash rate for an adjustment is \$50.00. Co-pay and co-insurance amounts vary. These fees are also called point-of-service fees as they are paid at the time services are rendered. Understand also that this is a *discounted* fee and that our regular fees range from \$95-\$170.00 per visit (dependent on therapies performed including ultrasound, heat, massage, muscle stim, etc.). Since this is a *discounted* rate off of our usual fees, if, at any time, you have any other coverages either through insurance, an auto accident, or workers compensation claim, please notify our office immediately so that we can make efforts to receive our regular fees.

**WORKERS COMPENSATION:** Patients are not responsible for any costs incurred with a workers comp injury with the possible exception of supplements. You are also entitled to mileage reimbursement and our office can provide you with print outs of your visits for you to fill out the mileage paperwork provided by workers comp for you to be reimbursed.

**PERSONAL INJURY:** Otherwise known as auto accidents and sometimes, slip and falls. The fees for personal injury cases range from \$95-\$170.00 per visit, dependent on the therapies you receive. With these slightly higher rates, extended wait time for payment is considered as is elaborate documentation of the patients care, including lengthy narrative reports, etc. Also, our charges are used by the responsible parties insurance to determine the extent of the patients need for care and are also used in calculating settlement offers to the patient. Therefore, we itemize all services performed at the visit and charge for them accordingly. If our final bill is not paid by your attorney, med-pay or a third party payor, you are ultimately responsible for payment of your account.

**INSURANCE:** If your health insurance offers coverage, we will do our best to verify your benefits and bill it in accordance with any contractual guidelines, usually these charges range from \$65-150.00 dependent on the therapies you receive. All billing is done as a courtesy to you, to help offset your cost, however, there may be times when we are mis-quoted information or payment is not made as described by your insurance. These additional amounts are your responsibility and we will do our best to keep you apprised of any information regarding your benefits if they should change. If your health coverage or health condition changes, you must notify the Doctor immediately. You are also responsible for payment of any deductibles, co-pays, and co-insurance amounts not covered by your insurance.

**CANCELLATION FEES:** Please note that massage therapy cancellation requires **24-hour notice** to avoid a cancellation fee of \$30.00 for an hour and \$15 for a ½ hour massage. Please understand that we pay the therapists for all visits not cancelled with 24-hour notice and therefore we must, in-turn, charge the patient missed appointment fees for massage only.

All fees charged at Leucadia Chiropractic are reasonable and in keeping with industry standards. We use the workers compensation fee schedule as a guideline for setting our fees, as is also typically done in the chiropractic industry.

I have read and understand the fees charged at Leucadia Chiropractic.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# Health Status Questionnaire

## YOUR PHYSICAL LIFE

Rate based on a frequency scale of 1-5. 1= Never 2= Rarely 3= Occasional 4= Regularly 5= Constantly

Presence of physical neck/backache pain, headaches...	1	2	3	4	5	Incidence of nausea, diarrhea or constipation	1	2	3	4	5
Feelings of tension, stiffness, lack of flexibility.	1	2	3	4	5	Incidence of allergies, eczema, or skin rash.	1	2	3	4	5
Incidence of fatigue or low energy.	1	2	3	4	5	Incidence of dizziness or lightheadedness.	1	2	3	4	5
Incidence of colds or flu.	1	2	3	4	5	Ability to work out or engage in activity	1	2	3	4	5

## MENTAL/EMOTIONAL STATE

Rate based on a frequency scale of 1-5. 1= Never 2= Rarely 3= Occasional 4= Regularly 5= Constantly

Presence of negative/ feelings or negative energy	1	2	3	4	5	Being overly worried about small things.	1	2	3	4	5
Moodiness, temper, or angry outbursts.	1	2	3	4	5	Difficulty thinking or concentrating.	1	2	3	4	5
Difficulty falling or staying asleep.	1	2	3	4	5	Feelings of depression or anxiety.	1	2	3	4	5

## STRESS EVALUATION

Rate based on how the level of stress these areas cause you. 1= None 2= Rare 3= Occasional 4= Regular 5= Constant

Family	1	2	3	4	5	Work/School	1	2	3	4	5
Significant relationship	1	2	3	4	5	General well-being	1	2	3	4	5
Health	1	2	3	4	5	Emotional well-being	1	2	3	4	5
Finances	1	2	3	4	5	Coping with daily problems	1	2	3	4	5

## LIFE ENJOYMENT

Rate based on the level of enjoyment experienced. 1= Extensive 2= Considerable 3= Moderate 4= Slight 5= None

Experiences of relaxation, ease, or well-being.	1	2	3	4	5	Compassion and acceptance of others.	1	2	3	4	5
Interest in maintaining a healthy lifestyle, diet, etc.	1	2	3	4	5	The level of recreation in your life.	1	2	3	4	5
Confidence in your ability to deal with adversity.	1	2	3	4	5	Time devoted to things you enjoy.	1	2	3	4	5

## OVERALL QUALITY OF LIFE

Rate based on the level of enjoyment experienced. 1= Delighted 2= Mostly Satisfied 3= Mixed 4= Dissatisfied 5= Unhappy

Your personal life.	1	2	3	4	5	The handling of the problems in your life.	1	2	3	4	5
Your spouse/significant other.	1	2	3	4	5	Your physical appearance.	1	2	3	4	5
Your job and the work you do.	1	2	3	4	5	The way you adjust to changes in your life.	1	2	3	4	5



## Health Goals

Of the many aspects of your life, where does your health and wellness rate as a priority (1 is highest and 5 is lowest):

1     2     3     4     5

So that we may exceed your expectations, please rate each area below based on their importance to you (1 is high priority, 5 is low):

\_\_\_\_\_ Money    \_\_\_\_\_ Value    \_\_\_\_\_ Time    \_\_\_\_\_ Service    \_\_\_\_\_ Results

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

\_\_\_\_\_

\_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_



LEUCADIA CHIROPRACTIC CLINIC

Patients Name: \_\_\_\_\_ ID#: \_\_\_\_\_

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE(ABN)

NOTE: If Medicare doesn't pay for the services listed below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the following services:

Table with 3 columns: Items or Services, Reason Medicare May not Pay, Estimated Cost. Rows include Exams and Re-Exams, X-Rays, Supplements, Support Braces, Pillows, Massage Therapy, Ultrasound & E-Stim, K-Laser.

What you need to know:

- Read this notice so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive any of the services listed above.

NOTE: If you choose option 1 or 2, we may help you to use any other insurance you might have, but Medicare cannot require us to do this.

OPTIONS: PLEASE CHOOSE ONLY ONE OPTION.

Option 1. YES, I want to receive the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

Option 2. YES, I want to receive the items or services listed above, BUT, do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

Option 3. NO. I have decided NOT to receive these items or services. I understand with this choice, I am not responsible for payment and I cannot appeal to see if Medicare would pay.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227).

Signing below means that you have received and understand this notice. You may also receive a copy, if requested.

Signature of Patient of person acting on Patients behalf

Date