Langston CHIROPRACTIC

Today's Date __ / __ / _____

Account # _____

Personal Information

Name _____ Date of Birth _____ Age ____ Male/Female
Address _____ City _____ State _____ Zip _____
Home _____ Mobile _____ Mobile Carrier _____
Social Security # _____ Email _____
Occupation _____ Employer's Name _____
Status: Single / Married / Divorced / Widowed Spouse's Name _____
Primary Care Physician _____ Doctor's # _____

Tell us how you heard from us!

My Employer _____ My Friend _____
Facebook _____ Email _____
Newspaper _____ Event _____
I live here _____ Other _____

Emergency Contact

Full Name _____ Phone # _____
Relationship _____

Financial Information

Are your complaints due to an Auto Accident or Workplace Injury? YES / NO

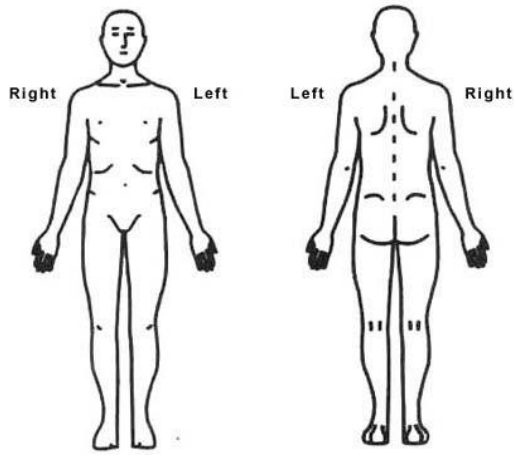
☐ Insurance ☐ Workers Comp ☐ Self Pay (CASH) ☐ Auto/Personal Injury ☐ Other_____

Primary Insurance

Name _____
Member ID _____ Group _____
Relation to insured: Self/Spouse/Parent/Child
Other than self:
Insured Name _____ Male/Female
Address _____
City_____State_____Zip_____
Phone_____DOB_____

Secondary Insurance

Name _____
Member ID _____ Group _____
Relation to insured: Self/Spouse/Parent/Child
Other than self:
Insured Name _____ Male/Female
Address _____
City_____State_____Zip_____
Phone_____DOB_____



(On a scale of 1 to 10, rate your discomfort as follows)

Neck-Shoulder-Arm Pain

0 10

Mid Back Pain

0 10

Low Back and Leg Pain

0 10

Describe Major Complaint _____
Began When? __/__/____ Describe how this began _____
_____
_____
Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe
How frequent is the complaint present? Off & On / Constant
Does the complaint radiate/shoot to any area of your body? No/Yes (Describe) _____
Head- Base of Skull/Forehead/Sides-Temples R / L *Leg*- Hip/Thigh-Knees/Calf/Toes-Foot R / L
Arm- Across Shoulder/Elbow/Hand-Fingers R / L *Other Area* _____
Does anything make the complaint better? Ice/ Heat/ Rest / Movement / Stretching / OTC / Other
Does anything make the complaint worse? Sit / Stand / Walk / Laying / Sleep / Overuse / Other
For the CURRENT condition:
Have you received any other treatment? None / DC / MD / PT / Massage / ER / Other
Had any previous Surgery or Interventions in this area? _____
Taken any Medications? OTC / Prescriptions _____
Any diagnostic testing? X-rays / MRI / CT / Other _____ When / Where_____
Describe any Secondary Complaints _____
_____

Medications:
Allergies to Medications _____
Current Medications _____
Past Health History
Surgeries (Date, Type, Reason) _____
Major Injuries/Trauma_____
Minor Injuries/Trauma_____
Family Health History
List relevant major health problems of immediate relatives_____
Deaths in immediate family (Cause and what age?) _____
Social History
Level of Education Completed: High School / Some College / College Grad / Post Grad
Lifestyle (Hobbies, Activities, Exercise, Vitamins) _____
Habits:
Cigarettes: Never/Former/Some Days/Current (#/day) _____
Alcohol (amount per day) _____
Coffee/Tea (cups per day) _____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE:

DIZZINESS	THROAT ISSUES	KIDNEY PROBLEMS	LIVER DISEASE	NERVOUSNESS
HEADACHES	THYROID PROBLEMS	MID BACK PAIN	SHOULDER PAIN	EPILEPSY
VERTIGO	ASTHMA	IRRITABLE BOWEL	CHRONIC FATIGUE	DISC PROBLEM
EAR INFECTIONS	ULCERS	SCIATICA	LUPUS	INFERTILITY
NAUSEA	NUMBNESS IN ARMS	NUMBNESS IN LEGS	FIBROMYALGIA	GASTRIC REFLEX
TMJ	NUMBNESS IN HAND	NUMBNESS IN FEET	CHEST PAIN	OTHER:
NECK PAIN	MENSTRUAL DISORDER	LOW BACK PAIN	ARM PAIN	_____
MIGRAINES	HEART DISORDER	HIP PAINS	ADD/ADHD	_____
ANXIETY	STOMACH DISORDER	LEG PAINS	RHEUMATOID A.	_____
CHRONIC SINUS	BLADDER PROBLEMS	KNEE PAIN	OSTEOPOROSIS	_____

Activities Of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY	EFFECT			
Sit to Stand	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Climbing Stairs	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Extended Computer Use	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Household Chores	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Lifting Children	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Shaving	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sexual Activities	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sleep	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Static Sitting	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Static Standing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Washing/Bathing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sweeping/Vacuuming	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Yard work	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Garbage	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Concentration (Reading)	No Effect	Painful (can do)	Painful (limits)	Unable to Perform

Informed Consent

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

> I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

Patient or Authorized Person's Signature _____ Date __ / __ / ____

For A Minor/Child, Please Fill Out and Sign Below Written Consent For A Child

Name of patient who is a minor/child: _____ _____

I authorize Dr. Jacob Langston and Dr. Jenna Langston and any and all Langston Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child.

As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Langston Chiropractic.

Guardian Signature _____ Date: __ / __ / ____

Relationship to Minor / Child _____

Notice of Privacy Practices Acknowledgement

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

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge and agree that Langston Chiropractic runs an open setting where incidental disclosures may occur. I agree that my personal health information may be used or disclosed for referrals to other health care providers with my permission, any billing or collection activities. I understand that the practice may leave messages on answering machines or make phone calls regarding scheduling of appointments, health benefit coverage and related discussion of care, including phone or mail notifications of any internal office promotions.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature _____ Date __ / __ / ____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctors of Langston Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name _____ Date of Birth __ / __ / ____

Signature _____ Date __ / __ / ____

FEMALE PATIENTS ONLY
To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time x-rays are taken at Langston Chiropractic.

Signature _____ Date __ / __ / ____

Langston Chiropractic
Dr. Jacob Langston | Dr. Jenna Langston
Medical Information Release Form (HIPAA Release)

Name _____ Date of Birth __ / __ / ____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed _____ Date __ / __ / ____