chiropractic

Bringing Out The Best In You!

Leverenz Family Chiropractic
2915 Lapeer Rd.
Port Huron, MI 48060
810-985-0084
www.2spinedocs.com

New Patient Welcome To Our Office

Date _____

Name _____ Preferred name _____

Address _____

City/State/Zip _____

Phone #s (home) _____ (cell) _____

Email address _____

SS # _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Is it okay to contact you at work? ❍ no ❍ yes Work # _____

Marital status ❍ single ❍ married ❍ separated ❍ divorced ❍ widowed

Spouse's name _____ Phone #(s) _____

Children's names and ages _____

_____

Do you have any pets? ❍ no ❍ yes If yes, please tell us what kind(s) _____

_____

Favorite hobbies or interests _____

Emergency contact: Name _____

Relationship _____ Phone #(s) _____

What Brings You Here?

Have you ever had chiropractic care before? ❍ no ❍ yes

If yes, please tell us who _____ Phone # _____

Were you pleased with your care? ❍ no ❍ yes

How did you find out about our office? _____

Is this appointment related to ❍ work ❍ sports ❍ auto
❍ personal injury ❍ other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone # _____

Are you receiving care from other health professionals? ❍ no ❍ yes

If yes, please name them and their specialty _____

_____

Please list any drugs or medications you are taking _____

_____

Please list any vitamins/herbs/homeopathics/other you are taking _____

_____

_____

Are you pregnant? ❍ no ❍ yes If yes, what month? _____

This form continues. Please turn the page.

Current Health

What are your pressing health concerns? _____

_____

_____

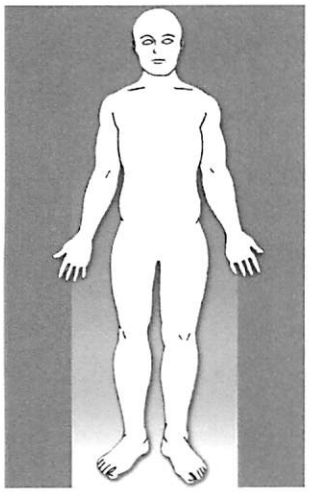
_____

_____

For how long? _____

Is it ❍ getting worse ❍ improving ❍ intermittent ❍ constant ❍ can't say

Where is the problem? Please use the illustrations and lines below to explain.



❍ Front _____

_____

_____

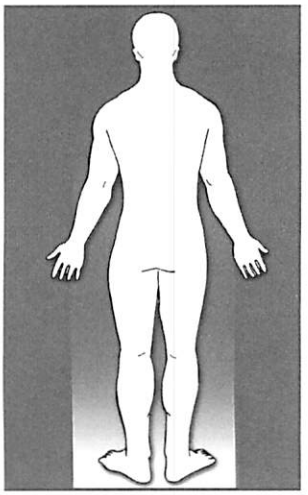
_____

❍ Back _____

_____

_____

_____



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by ❍ sitting ❍ standing ❍ walking

❍ bending ❍ lying down ❍ weather ❍ other

Please explain _____

_____

Do you feel ❍ cramps ❍ burning ❍ stiffness ❍ swelling ❍ other

Please explain _____

_____

Do your symptoms interfere with ❍ work ❍ sleep ❍ day-to-day activities

❍ play ❍ other _____

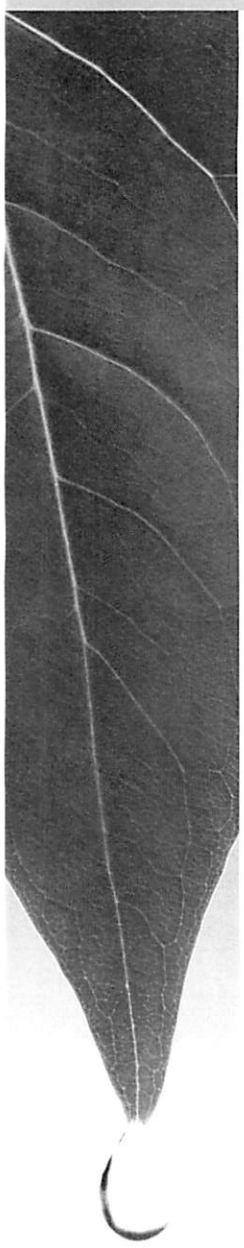
Please explain _____

_____

_____

On a scale of 1-10 (1 least, 10 most), please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10



Health History

Do you have, or have you had, any of the following (please check ☑ all that apply)?

❍ pneumonia	❍ mumps	❍ influenza	❍ rheumatic fever	❍ smallpox
❍ pleurisy	❍ polio	❍ chickenpox	❍ thyroid disease	❍ diabetes
❍ epilepsy	❍ cancer	❍ depression	❍ whooping cough	❍ anemia
❍ eczema	❍ measles	❍ arthritis	❍ heart disease	❍ rashes
❍ colitis	❍ stroke	❍ allergies _____		

If you have ever been diagnosed with another disease or condition, please describe _____

_____

Do you drink ❍ coffee ❍ tea ❍ alcohol

Do you use ❍ cigarettes ❍ recreational drugs ❍ artificial sweeteners ❍ sugar

Have you ever suffered from (please check ☑ all that apply)

❍ neck pain	❍ difficulty breathing	❍ discolored urine
❍ low back pain	❍ stuffy nose	❍ gas/bloating after meals
❍ headache	❍ fainting	❍ heartburn
❍ migraines	❍ weight loss	❍ irritable bowel
❍ arm pain/tingling	❍ poor appetite	❍ black or bloody stools
❍ shoulder pain	❍ excessive appetite	❍ constipation
❍ hand pain/tingling	❍ nervousness	❍ hemorrhoids
❍ leg pain/tingling	❍ confusion	❍ liver problems
❍ jaw pain	❍ depression	❍ paralysis
❍ chest pain	❍ dental problems	❍ numbness
❍ lung problems	❍ excessive thirst	❍ fatigue
❍ heart problems	❍ frequent nausea	❍ dizziness
❍ abnormal blood pressure	❍ prostate problem	❍ loss of sleep
❍ irregular heartbeat	❍ breast pain/lump	❍ difficulty hearing
❍ ankle swelling	❍ cramps	❍ ear pain
❍ cold extremities	❍ painful urination	❍ other _____
❍ blurred vision	❍ bladder trouble	_____
❍ vision problems	❍ excessive urination	_____

If applicable, date of last menstrual period _____

Past injuries can affect present health (please check ☑ all that apply)

❍ falls/accidents	❍ head injuries	❍ fights	❍ surgery
❍ sports injuries	❍ broken bones	❍ dislocations	❍ other
❍ spinal tap	❍ knocked unconscious	❍ traction	_____
❍ use(d) a cane or walker	❍ extensive dental work	❍ dental applications	_____

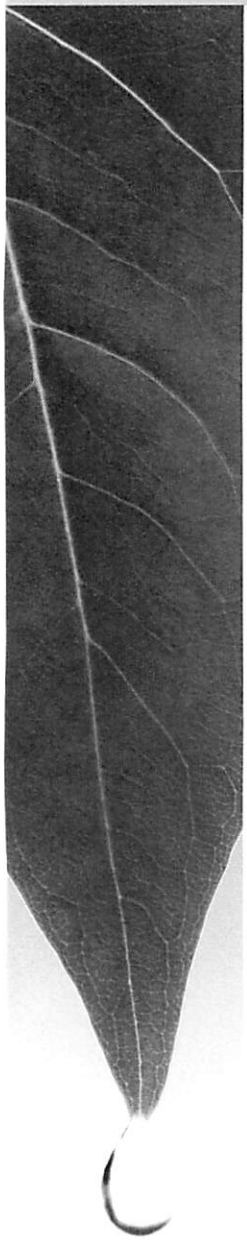
If yes to any of the above, please describe _____

_____

_____

_____

_____



What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what a subluxation is? ❍ no ❍ yes

If yes, please describe _____

_____

Do any friends or relatives see chiropractors: ❍ no ❍ yes

If yes, do they use chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

Are you seeking chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you? ❍ no ❍ yes

If yes, please tell us _____

_____

_____

_____

_____

_____

_____

_____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care? ❍ Cash ❍ Check ❍ Credit Card

Credit card # _____ Exp. _____

Insurance co. _____ Phone # _____

ID # _____ Group # _____

Subscribers's name _____ Phone # _____

Relation _____ Subscriber's employer _____

Subscribers's SS # _____ Subscriber's birthdate _____

The above is accurate to the best of my knowledge.

_____ _____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____

(signature) (date)

NAME_____AGE_____DATE_____DATE of INJURY_____

HEALTH STATUS QUESTIONNAIRE (HSQ-12)

1. In general would you say your health is : *(Circle one number)*
   - Excellent.....1
   - Very Good.....2
   - Good.....3
   - Fair.....4
   - Poor.....5

The following items are about activities you might do during the typical day. Does your health now limit you these activities? If so, how much? *(Circle one number on each line)*

	YES limited a lot	***YES limited a little***	***No, not limited at all***
2. Lifting or carrying groceries.....	1	2	3
3. Climbing several flights of stairs....	1	2	3
4. Walking several blocks.....	1	2	3

5. During the past **4 weeks** how much difficulty did you have doing your work or other regular daily activities as a result of your physical health? *(Circle one number)*

   - None at all.....1
   - A little bit.....2
   - Moderately.....3
   - Quite a bit.....4
   - Couldn't do any work...5

6. During the past 4 weeks, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems (such as feeling depressed or anxious)? *(Circle one number)*
   - None at all.....1
   - A little bit.....2
   - Moderately.....3
   - Quite a bit.....4
   - Extremely.....5

7. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? *(Circle one number)*
   - None at all.....1
   - Slightly.....2
   - Moderately.....3
   - Quite a bit.....4
   - Extremely.....5

8. How much bodily pain have you had during the past 4 weeks? *(Circle one number)*

None.....1
Very Mild.....2
Mild.....3
Moderate.....4
Severe.....5
Very Severe.....6

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes the closest to the way you have been feeling.

How much of the time during the past 4 weeks....*(Circle one number on each line)*

	All of **the time**	***Most of*** **the time**	***A good bit*** **of the time**	***Some of*** **the time**	***Little of*** **the time**	***None of*** **the time**
9. Have you felt calm and peaceful?	1	2	3	4	5	6
10. Did you have a lot of energy?	1	2	3	4	5	6
11. Have you felt downhearted and blue?	1	2	3	4	5	6
12. Have you been happy?	1	2	3	4	5	6

Please answer YES or NO for each question by circling "1" or "2" on each line.	**YES**	**NO**
13. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that, you usually cared about or enjoyed?	1	2
14. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?	1	2
15. Have you felt depressed or sad much of the time in the past year?	1	2

Patient Name: _____ D.O.B. ____/____/_____

Email: _____ Want text reminders? □ Yes □ No

Cell Phone #: _____

2018 Insurance:

Ins. Name: _____ **Cell Phone Provider:** _____

Ins. ID#: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than Chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

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Informed Consent to Care

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Pregnancy Release (Female only)

This is to certify that to the best of my knowledge I am **not** pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: _____

Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Disclaimer

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all moneys will be credited to my account upon receipt. I, also authorize the release of any health information necessary to process this claim. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, the fees for professional services rendered me will be immediately due and payable. In the event of default I agree to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____