Lincoln Chiropractic Specializing in Spinal Correction

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly **CONFIDENTIAL**.

Patient information

Date: _____ SSN: _____ Birthday: _____

First Name: _____ Middle Name: _____ Last Name: _____

Sex: ◯ M ◯ F Height: _____ Weight: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ DOB: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widow Spouse Name: _____ Number of children: _____

Referral information

Referring Physician: _____ Search Engine: _____ Event: _____

Advertisement: ◯ YES ◯ NO Social Network: _____ Other: _____

Personal Mailing: ◯ YES ◯ NO Friend/Relative: _____

Employer Information

Employed: ◯ Full Time ◯ Part Time ◯ Homemaker ◯ Unemployed

Employer Name: _____ Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Duties: _____

Primary Financial Information

◯ Health Insurance ◯ Self Pay Resp for Payment: _____ Resp Phone #: _____

Primary Name: _____ ID/SSN: _____ Group/Policy #: _____

Address: _____ City: _____ State: _____ Zip: _____

Complaint Information

Injury Occurred: ◯ Automobile ◯ Third-Party ◯ Other Date of Onset: _____

Injury Origin: _____ Palliative: (What makes better or worse?) _____

Quality: (What does it feel like?) _____ Radiation: _____ 1-10: _____

Timing/Frequency: ◯ Always ◯ Hourly ◯ Daily ◯ Occasionally ◯ A.M. ◯ P.M.

Interfere w/Activities: ◯ YES ◯ NO Affected Sleep? ◯ YES ◯ NO

Missed Work: ◯ YES ◯ NO Unable to work from: _____ Unable to work until: _____

Affected Appetite: ◯ YES ◯ NO Explain: _____

Reduced Work: ◯ YES ◯ NO Explain: _____

Weather Affects it: ◯ YES ◯ NO Explain: _____

Prev. Auto Accident: ◯ YES ◯ NO Explain: _____

Struck Unconscious: ◯ YES ◯ NO Explain: _____

X-rays Taken: ◯ YES ◯ NO Explain: _____

Existing Condition: ◯ YES ◯ NO Explain: _____

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History

Last Physical Exam: _____ Primary Physician: _____ Physician Phone #: _____

City: _____ State: _____ Zip: _____

Health Condition

Previous Chiro Care: ◯ YES ◯ NO Date: _____ Explain: _____

Chance Pregnant: ◯ YES ◯ NO

Medication: _____

Supplements: _____

Broken Bones: ◯ YES ◯ NO Explain: _____

Sprains/Strains: ◯ YES ◯ NO Explain: _____

Surgery: ◯ YES ◯ NO Explain: _____

Hospitalizations: ◯ YES ◯ NO Explain: _____

Infections or Immunizations: ◯ YES ◯ NO Explain: _____

Trauma: ◯ YES ◯ NO Explain: _____

Allergies: ◯ YES ◯ NO Explain: _____

Family Health Checklist S = Self F = Family

Allergies ◯ S ◯ F	Cold Extremities ◯ S ◯ F	**Heart Disease ◯ S ◯ F**	Poor Posture ◯ S ◯ F
Alcoholism ◯ S ◯ F	Constipation ◯ S ◯ F	High Blood Pressure ◯ S ◯ F	Prostate Trouble ◯ S ◯ F
Anemia ◯ S ◯ F	Cramps ◯ S ◯ F	Insomnia ◯ S ◯ F	Sciatica ◯ S ◯ F
Arteriosclerosis ◯ S ◯ F	Depression ◯ S ◯ F	Irregular heartbeat ◯ S ◯ F	Shortness of breath ◯ S ◯ F
Arthritis ◯ S ◯ F	**Diabetes ◯ S ◯ F**	Kidney Inf/Stones: ◯ S ◯ F	Sinus Infection ◯ S ◯ F
Asthma ◯ S ◯ F	Digestion Problems ◯ S ◯ F	Loss of Balance ◯ S ◯ F	Spinal Curvatures ◯ S ◯ F
Back Pain ◯ S ◯ F	Dizziness ◯ S ◯ F	Loss of Memory ◯ S ◯ F	**Stroke ◯ S ◯ F**
Breast Lump ◯ S ◯ F	Excess Menstruation ◯ S ◯ F	Loss of Smell ◯ S ◯ F	Swelling of Ankles ◯ S ◯ F
Brochities ◯ S ◯ F	Eye Pain/Difficulties ◯ S ◯ F	Loss of Taste ◯ S ◯ F	Swollen Joints ◯ S ◯ F
Bruise Easily ◯ S ◯ F	Fatigue ◯ S ◯ F	Other ◯ S ◯ F	Thyroid Condition ◯ S ◯ F
Cancer ◯ S ◯ F	Frequent Urination ◯ S ◯ F	Nosebleeds ◯ S ◯ F	Tuberculosis ◯ S ◯ F
Chest Pain ◯ S ◯ F	Headache ◯ S ◯ F	Pacemaker ◯ S ◯ F	Ulcers ◯ S ◯ F

Patient Social

Alcohol:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never	Caffeine:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Diet Food Products:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never	Drugs:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
OTC Stimulants:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never	Exercise:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Homemade Foods:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never	Processed Food:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Soft Drinks:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never	Smoke/Tobacco:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Water:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never	How is your sleep?	_____			
Sexually Active:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never					

Any other signs or symptoms that you have noticed since your symptoms began, even if you think are unrelated? _____

_____

_____

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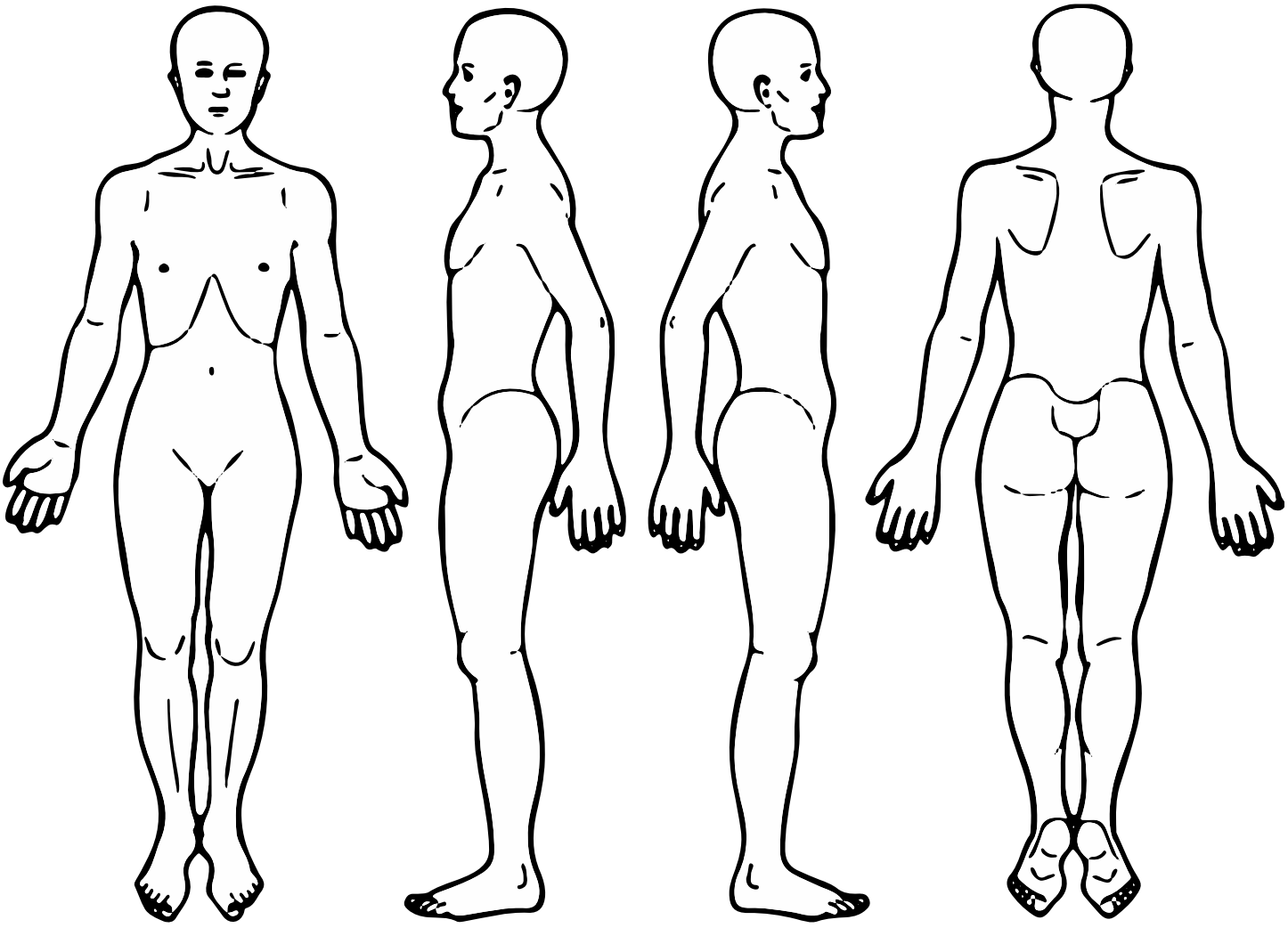
Current Discomfort Form

Mark where you have pain or discomfort by drawing 1, 2, 3, or 4 on the affected area

You may add lines, arrows, or circles to help describe your discomfort

1- Mild 2- Slight 3- Moderate 4- Severe



FRONT **LEFT** **RIGHT** **BACK**

List complaints (Worst to least)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Lincoln Chiropractic Specializing in Spinal Correction

Accident Information

Date and time of accident: _____ Location/Street of accident: _____

When the accident occurred, you were the: ◯ Driver ◯ Front Passenger ◯ Rear Passenger

Was this vehicle equipped with airbags? ◯ YES ◯ NO Did the airbags inflate? ◯ YES ◯ NO

Make and model of the vehicle you were occupying: Make: _____ Model: _____

Were you wearing a seat belt? ◯ YES ◯ NO

Make and Model of the *other* vehicle: Make: _____ Model: _____

Did the impact to your vehicle come from: ◯ Front ◯ Rear ◯ Right Side ◯ Left Side ◯ Other _____

In relation to the base of your skull, where was the headrest? ◯ Above ◯ Below ◯ At the base

In which direction were you headed? ◯ North ◯ South ◯ East ◯ West

In which direction was the other vehicle headed? ◯ North ◯ South ◯ East ◯ West

In which direction were you facing on impact? ◯ Forward ◯ Right ◯ Left

Did any part of your body strike anything in the vehicle? ◯ YES ◯ NO

Explain: _____

Did the accident render you unconscious? ◯ YES ◯ NO If yes, for how long? _____

What was the approximate speed of your vehicle? _____ What was the approximate speed of the other vehicle? _____

When the impact occurred, you were: ◯ Aware ◯ Surprised

What did your vehicle impact? ◯ A vehicle ◯ Other _____

If other, please explain here: _____

Number of people in accident: _____ Please list the names of the victims in this accident: _____

_____

In your own words, please describe the accident: _____

_____

Please describe how you felt immediately after the accident: _____

Legal Information

Did the police come to the accident? ◯ YES ◯ NO Was a policy report filed? ◯ YES ◯ NO

Were there any witnesses? ◯ YES ◯ NO

Was a traffic violation issued? ◯ YES ◯ NO If yes, whom? _____

Have you retained an attorney? ◯ YES ◯ NO If yes, whom? _____

Patient Automobile Insurance

Insurance Company Name: _____ Effective Date: _____ Policy #: _____

Insurance Company Phone #: _____ Name of Adjuster: _____ Claim #: _____

Medical Information

Have you gone to a hospital or seen any other doctor? ◯ YES ◯ NO Was medication prescribed ◯ YES ◯ NO

When did you go? ◯ Immediately ◯ Next day ◯ 2 Days Plus How did you get there? ◯ Ambulance ◯ Private Transportation

Name of hospital and/or attending doctor: ◯ D.D.S ◯ M.D. ◯ D.C. ◯ D.O.

Were any x-rays taken? ◯ YES ◯ NO Have you been able to work since the injury? ◯ YES ◯ NO

Are your work activities restricted as a result of this injury? ◯ YES ◯ NO

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CONSENT FOR TREATMENT INFORMATION

I certify that I'm the patient or legal guardian. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to "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 or your health if you choose not to receive care.

I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination or my care or treatment.

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

We may conduct some diagnostic or examination procedures if indicated. Any examination or test conducted will be carefully performed but may be uncomfortable. When providing an adjustment. we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits or treatment include normal joint function. reduction of swelling and inflammation in a joint, reduction of pain, and improving neurological functioning and overall well-being,

I understand and I am informed that, as is with all Healthcare treatments, there are some risks to treatment, including but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed, and there is no promise to cure.

I understand that there are treatment options available for my 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, rest, medical care, prescription medications, physical therapy, bracing, injections, and surgery.

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 the 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 circumstances. 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. I certify my health information & forms to be true and correct to the best of my knowledge, and hereby authorize the Chiropractic office of Dr. Stephen Leamon to provide me with chiropractic care, in accordance with this state's statutes.

Patient: _____ Date: _____ Parent/Guardian: _____ Date: _____

HIPPA PRIVACY NOTICE AND OTHER PROVISIONS

Lincoln Chiropractic/Dr. Stephen Leamon's Privacy Notice is available on our website at drstephenleamon.com and at the front desk for patients who request a copy. I hereby acknowledge that I have been offered a copy or the Notice of Privacy Practices from Lincoln Chiropractic/Dr. Stephen Leamon and have been informed of my additional rights under HIPPA.

Patient: _____ Date: _____ Parent/Guardian: _____ Date: _____

OFFICE USE ONLY

In lieu of the patient signature, I, _ , a staff member, state that this patient has been offered our current Notice of Privacy Practices.

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FINANCIAL, MEDICAL RELEASE AND ASSIGNMENT OF BENEFITS GUIDELINES

Our goal is your good health. If you have a financial hardship, please let us know and we will be more than happy to work with you. We never want money to stand in the way of you getting the care you need.

TIMELY APPOINTMENTS - I understand when I schedule an appointment that I am reserving time specifically for me and no-showing or cancelling at the last minutes does not allow Dr. Stephen Leamon to reappointment another patient in need of care. I understand that if I'm unable to keep my reserved appointment and need to reschedule for any reason, I will provide a 24-hour minimum notice. If this becomes a reoccurrence there may be a charge.

FINANCIAL AGREEMENT - I acknowledge that payment is due at the time of treatment unless other arrangements are made. I understand that parents/guardians are responsible for all fees and services rendered for treatment for myself and/ or child. I accept full financial responsibility for all charges for services or items provided to me or my child. I understand that filing claims with my insurance company does not relieve me from my responsibility for the payment of all charges. I understand that I am responsible for all costs or chiropractic care, regardless of insurance coverage. I also understand that it I suspend or terminate my schedule of care, as determined by my treating doctor, any fees for professional services will be immediately due and payable. Accordingly, I understand that all payment(s) for treatment(s) are final, and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel future treatment. Any previous discount(s) will be null, and void and refunds will be recalculated according to the full office fee schedule before being refunded. I understand that interest, in the amount of 1.5% per month or 18% per annum, will accrue for any balance over 60 days and that any balance over 90 days may be turned over to collections and I will be responsible for all collection and attorney fees.

INSURANCE COPAYMENTS - I understand Dr. Stephen Lemon's office estimates as close as possible to what my copayment amount may be, realize there is no guaranty of payment from my insurance carrier and that my health/accident insurance policies are arrangement between me and my insurance carrier. I further understand that if my insurance payment is not received within 60 days from the time of service that I will be responsible for the services rendered, in full, regardless or insurance coverage. I understand I am financially responsible for copayments, coinsurance, or deductibles for covered services, as well as those services that exceed benefit limits. I am also financially responsible for all non-covered services as defined by my health plan contract. This may include, but is not limited to, vitamins & supplements, supports, strapping, and maintenance care.

ASSIGNMENT OF BENEFITS – I, the undersigned, have insurance and hereby assign and convey directly to Dr. Stephen Leamon all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all medical information necessary to process my claims. I hereby authorize any plan administrator or fiduciary, insurer, adjuster, and my attorney, to release to such doctor any and all plan documents, insurance policy, and or settlement information, upon written request from such doctor to claim such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

This assignment will remain in effect until revoked by me, in writing, and presented to Dr. Stephen Leamon. A photocopy of this assignment is to be considered as valid as the original.

You may share my health and account information with the following people:

1. _____ 3. _____
2. _____ 4. _____

We cannot speak with anyone concerning your care or your bill unless they are listed above, or we have a signed medical release on file.

IMAGE/SOCIAL MEDIA CONSENT

I consent that Lincoln Chiropractic may use photograph images or videos of me taken for their social media or website, and I understand these images and/or videos will not be used for any other commercial purpose.

If you do not want your image or video information used, please initial here: _____

I have read in its entirety and fully understand these agreements.

Patient: _____ Date: _____ Parent/Guardian: _____ Date: _____