Larson Family Chiropractic
New Patient Intake Form

Today's Date:_____

Name Last:_____ First: _____Middle:_____
Preferred Name: _____DOB:_____ Age:_____
Birth Sex: Male Female Marital Status: S M D W

Mailing Address:_____
City:_____State:_____Zip:_____

Home Phone:(__) _____Cell Phone:(__)_____Email Address:_____
Preferred Contact Method: _____

Self Employed/Retired Employer: _____Occupation: _____
Student: Y/N If Yes: Full Time/Part Time Name of School_____
Legal Guardian's Name:_____
Contact #_____

In Case of Emergency Contact:_____
Phone Number: (____)_____

Would you like us to release your information to any person or establishment?
Name: _____ Relationship:_____
Name: _____ Relationship:_____

May we contact your primary care physician? Yes No
Name of physician:_____ Phone Number: (__)_____

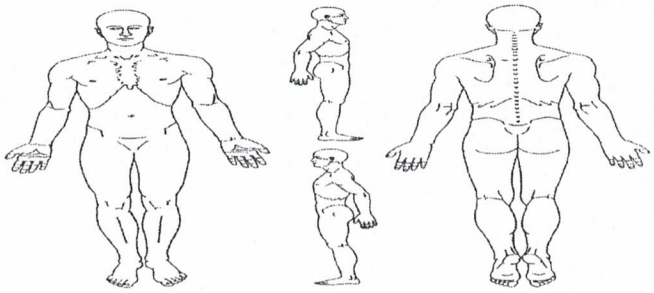
WHO REFERRED YOU TO US?_____
Google Website Ad

Larson Family Chiropractic
Patient History Form

Patient Name: _____ Date:_____

PLEASE CHECK ALL ANSWERS THAT APPLY AND FILL IN BLANKS WHERE APPROPRIATE. The information you provide concerning your medical history assists your doctor in understanding your state of health. This is important information. Please be thorough.

Please circle the **ONE** area of the body in the diagram below that is your **MOST IMPORTANT CONCERN**.



Is the complaint: • an ongoing issue, • an aggravation of a chronic issue, • brand new problem, • a recent problem
When did this episode begin: _____ Date OR • chronic ongoing
What happened in life to cause or flair up this problem: _____
Is the discomfort: • constant • Frequent • Intermittent • Off and On • Random, Other _____
What is the quality of the pain? (Check all that apply)
• Dull •Ache • Annoying • Stiff • Burning • Deep • Diffuse • Sharp • Stabbing • Throbbing • Heavy • Tingling • Pulling
Does the pain radiate or travel anywhere? If so, where? _____
Is there tingling or numbness associated with this problem? If so, where? _____
Has this complaint: • worsened since onset, • stayed the same • improved since onset
On a scale of 0-10 with 10 being THE WORST PAIN IMAGINABLE (completely debilitating), where would you rate your pain when it is at its worst? ____/10 On the same scale where would you rate it at this time? ___/10
Which of the following increases your pain? • prolonged sitting • prolonged standing • physical demands of work • lifting • bending • looking over your shoulder • changing positions • computer use • getting out of the car • household chores • shopping • getting up from lying down or sitting • heavy activity • moderate activity • light activity • twisting •walking • stress • noise • light • Other _____
Which of the following decreases your pain? • activity/moving around • applying ice • applying heat • stretching • rest • chiropractic adjustments • lying down • exercise • massage • over the counter medication • Prescription medication • Other _____
Have you experienced a similar problem in the past? • Yes • No If Yes, compared to this episode were the symptoms:
• Similar to this episode • Not as severe as this episode • Worse than this episode • Different from before
What care have you received for this issue in the past? • None • Over the counter medication • Prescription medication • surgery • chiropractic care • medical care • physical therapy • injection therapy • acupuncture
• Other: _____
What Activities of Daily Living are most affected by this issue? • None • All of them • sitting • traveling/driving • lifting • physical demands of employment • repetitive movement of the involved area • prolonged sitting or standing • computer work • household chores • getting adequate sleep • any activity involving the problem area • personal care • sexual relations • socializing • Other _____
What functional goals do you hope to achieve with treatment for this complaint?
• have no functional limitations • manage chronic pain • relieve or resolve pain • improve pain-free range of motion • manage frailty/fall risk factors • sleep through night without pain • be able to lift without pain • improve strength • improve flexibility and function • decrease stiffness • slow function loss from arthritis • return to work without limitation • Other _____
Has there been any imaging of the area of complaint in recent history? • None • X-Ray • MRI • CT • Bone Density • Ultrasound • Nerve conduction studies • Other: _____ If so, when? _____

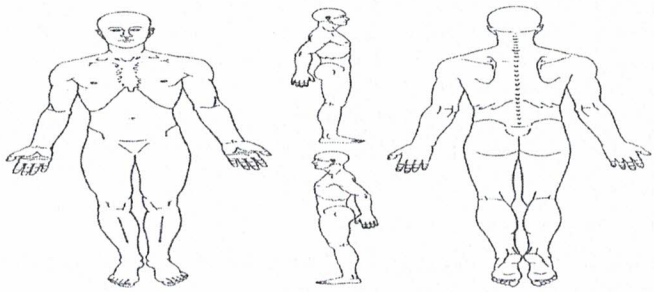
Larson Family Chiropractic

Patient Additional Complaint Form
Larson Family Chiropractic

Patient Name:_____ Date:_____

PLEASE CHECK ALL ANSWERS THAT APPLY AND FILL IN BLANKS WHERE APPROPRIATE. The information you provide concerning your medical history assists your doctor in understanding your state of health. This is important information. Please be thorough.

Please circle the areas of the body in the diagram below for your **ADDITIONAL COMPLAINT.**



Is the complaint: • an ongoing issue, • an aggravation of a chronic issue, • brand new problem, • a recent problem
When did this episode begin: _____ Date OR • chronic ongoing
What happened in life to cause or flair up this problem: _____
Is the discomfort: • constant • Frequent • Intermittent • Off and On • Random, Other _____
What is the quality of the pain? (Check all that apply)
• Dull •Ache • Annoying • Stiff • Burning • Deep • Diffuse • Sharp • Stabbing • Throbbing • Heavy • Tingling • Pulling
Does the pain radiate or travel anywhere? If so, where? _____
Is there tingling or numbness associated with this problem? If so, where? _____
Has this complaint: • worsened since onset, • stayed the same • improved since onset
On a scale of 0-10 with 10 being THE WORST PAIN IMAGINABLE (completely debilitating), where would you rate your pain when it is at its worst? ____/10 On the same scale where would you rate it at this time? ___/10
Which of the following increases your pain? • prolonged sitting • prolonged standing • physical demands of work • lifting • bending • looking over your shoulder • changing positions • computer use • getting out of the car • household chores • shopping • getting up from lying down or sitting • heavy activity • moderate activity • light activity • twisting •walking • stress • noise • light • Other _____
Which of the following decreases your pain? • activity/moving around • applying ice • applying heat • stretching • rest • chiropractic adjustments • lying down • exercise • massage • over the counter medication • Prescription medication • Other _____
Have you experienced a similar problem in the past? • Yes • No If Yes, compared to this episode were the symptoms:
• Similar to this episode • Not as severe as this episode • Worse than this episode • Different from before
What care have you received for this issue in the past? • None • Over the counter medication • Prescription medication • surgery • chiropractic care • medical care • physical therapy • injection therapy • acupuncture
• Other: _____
What Activities of Daily Living are most affected by this issue? • None • All of them • sitting • traveling/driving • lifting • physical demands of employment • repetitive movement of the involved area • prolonged sitting or standing • computer work • household chores • getting adequate sleep • any activity involving the problem area • personal care • sexual relations • socializing • Other _____
What functional goals do you hope to achieve with treatment for this complaint?
• have no functional limitations • manage chronic pain • relieve or resolve pain • improve pain-free range of motion • manage frailty/fall risk factors • sleep through night without pain • be able to lift without pain • improve strength • improve flexibility and function • decrease stiffness • slow function loss from arthritis • return to work without limitation • Other _____
Has there been any imaging of the area of complaint in recent history? • None • X-Ray • MRI • CT • Bone Density • Ultrasound • Nerve conduction studies • Other: _____ If so, when? _____

If you have ever had a symptom listed below in the past, please check the PAST column. If you are presently troubled by a particular symptom, check the PRESENT column.

PAST	PRESENT		PAST	PRESENT	
•	•	Arthritis (Osteoarthritis)	•	•	High Blood Pressure
•	•	Rheumatoid Arthritis	•	•	High Cholesterol
•	•	Back problems	•	•	History of Heart Attack
•	•	Posture issues	•	•	History of Chest Pain (Angina)
•	•	Knee problems	•	•	Atrial Fibrillation or Pacemaker
•	•	Joint or muscle pain/stiffness	•	•	Swelling of legs or feet
•	•	Foot or Ankle pain	•	•	Coronary Artery Disease
•	•	Hip problems	•	•	Palpitations
•	•	Shoulder problems	•	•	Varicose Veins
•	•	TMJ (Jaw) issues	•	•	History of Blood Clots _____.
•	•	Elbow/Wrist pain	•	•	Difficulty Swallowing
•	•	Scoliosis	•	•	Apnea
•	•	History of fracture	•	•	Asthma
•	•	Pins or screws	•	•	COPD
•	•	Gout _____.	•	•	Seasonal Allergies _____.
•	•	Anxiety/Depression	•	•	GERD
•	•	Difficulty concentrating	•	•	Changes in bowel habits
•	•	Dizziness	•	•	Irritable Bowel Syndrome
•	•	Peripheral Neuropathy	•	•	Food/Chemical sensitivity
•	•	Pins and Needles	•	•	Painful/Frequent urination
•	•	Headache	•	•	UTI/Bladder Infections
•	•	Loss of smell or taste	•	•	Benign Prostatic Hypertrophy
•	•	Memory issues	•	•	Incontinence
•	•	Numbness	•	•	Diabetes
•	•	Epilepsy or Seizures	•	•	Hypo-Thyroid
•	•	Sleep issues	•	•	Hyper-Thyroid
•	•	Stroke	•	•	Blood in stool
•	•	Pregnancy	•	•	Easy Bruising
			•	•	Animal or Dairy Allergies

Medications: _____

Surgical History: _____

Trauma: Please list all motor vehicle collisions, bad falls, broken bones, etc. in your lifetime.

History of Cancer: _____

Family History: (D: Dad, M: Mom, S: Sister, B: Brother, PGM: Dad's Mom, PGF Dad's Dad, MGM: Mom's Mom, MGF: Mom's Dad)

D/M/S/B/PGM/PGF/MGM/MGF	• Heart Disease	•Stroke	• High Blood Pressure	• Cancer	• Diabetes
D/M/S/B/PGM/PGF/MGM/MGF	• Heart Disease	•Stroke	• High Blood Pressure	• Cancer	• Diabetes
D/M/S/B/PGM/PGF/MGM/MGF	• Heart Disease	•Stroke	• High Blood Pressure	• Cancer	• Diabetes
D/M/S/B/PGM/PGF/MGM/MGF	• Heart Disease	•Stroke	• High Blood Pressure	• Cancer	• Diabetes

Work Status:

• Full time employment • Part time employment • Retired • Disabled • Unemployed

• Full time student • Part time student • Active Military

Alcohol Consumption: • None • 1-2 drinks/week • 1-2 drinks/day • 2-3 drinks/day • 3+ drinks/day

Smoking: • Never • Quit • Light • Moderate • Heavy

Recreational Drugs • None • Rare • Moderate • Heavy • In Recovery

Exercise: • Daily • Few times per week • Sporadically • Rarely • Never

Do you have a permanent disability rating? •Yes •No Body Part _____

Date you received disability rating: ____/___/____ Disability Percentage: _____%

To the best of my knowledge all this information is correct.

Patient Signature _____ Date: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. _____Initial

Furthermore, I understand that Larson Family Chiropractic will prepare any necessary reports and forms once to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I agree that any balance not paid by my insurance company within 45 days will be paid by me and I can then seek reimbursement from my insurance carrier on my own. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. _____Initial

I understand and agree that any service that I have received has been ordered based upon what is best for me and that my insurance company may not consider this a covered benefit. I understand that I am responsible for all charges. _____Initial

I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. ____Initial

This is to serve as a long-term authorization card. This authorization is to apply to all occasions of service until revoked in writing. This authorization gives Larson Family Chiropractic the authority to act on my behalf in attempting to collect for services rendered to me. _____ Initial

I understand that should my account become delinquent and legal action is taken I am responsible for all costs that may incur. _____Initial

I have read and understand the HIPAA rules and regulations in effect at Larson Family Chiropractic. ____ Initial

I understand that I may be charged an interest rate of 1.5% on any delinquent balance over 60 days. _____Initial

I understand that should I need to cancel an appointment I need to give a 24-hour notice. If I cancel or no show with less than 24 hours 2 times, I will be charged the full price of the 2nd missed appointment. I understand that my insurance carrier will not be billed for this and that I am fully responsible for this charge. _____Initial

I understand that payment is expected at time of service. I understand that if payment arrangements are needed, I must make them prior to receiving treatment. _____Initial

I understand that should either my insurance carrier or myself request copies of my records I am financially responsible for this charge. (.10 per page) _____Initial

I understand and agree with all the terms and conditions set before me and I wish to have treatment with Larson Family Chiropractic.

Patient's Signature _____ Date _____
Guardian/Spouse Signature Authorizing Care _____ Date _____
Relationship to patient _____
If Guardian has medical consent a copy of the form must be kept on file.

Larson Family Chiropractic
Informed Consent Document

Patient Name: _____ Date: _____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.
One of the primary treatments used by doctors of chiropractic is spinal manipulative therapy. We will likely use that procedure to treat you. We may do this with our hands or with a mechanical instrument in such a way as to move your joints. That may or may not cause an audible " pop "or "click," much as you experience when you " crack" your knuckles. You may feel a sense of movement.

The risks inherent in chiropractic treatment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic care. These complications include but are not limited to: muscle strain, rib sprain/strain, fractures, disc damage, dislocations, cervical myelopathy, costovertebral separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.
Fractures are extremely rare occurrences and generally result from some underlying weakness of the bone which we check for while taking your history and during examination. Stroke and / or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incidence of this complication occurring. If there is a causal relationship at all it is extremely rare and remote.

The availability and nature of other treatment options.
Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above-noted options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical provider.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction, further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. Deferred care may also permit further progression of degenerative arthritis.

CONSENT TO TREATMENT (MINOR)
I hereby request and authorize Larson Family Chiropractic doctors and staff to perform diagnostic tests and render chiropractic
adjustments and other treatment to my minor son/daughter: _____.

(Continued on Next Page)

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed any questions that I have with Larson Family Chiropractic and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Signature : _____ Date: _____

Signature of Parent or Guardian (if a minor): _____ Date:_____

Larson Family Chiropractic
7749 E Florentine Rd, Prescott Valley, AZ 86314
Office: 928-771-9400
Fax: 928-771-9460

HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Larson Family Chiropractic, ("Covered Entity") will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

You acknowledge and agree that Covered Entity may use or disclose your protected health information for the purpose(s) of Planning your care and treatment, for payment for treatment and services that you receive, appointment reminders, means of communication among the many health professionals who contribute to your care, legal document describing the care you received, means by which you or a third-party payer can verify that services billed were actually provided, a source of information for public health officials charged with improving the health of this sate and the nation, unless you notify us that you object, we may use your name and general condition in the event that you are transported to a hospital to other people who ask for you by name, notification and or communication with family members when the health professional, using their best judgment my disclose your personal information to notify family members or other people you identify with information relevant to your care or payment information related to your care, marketing to provide you with appointment reminders or information about alternative treatments that may be of interest to you.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to the above location(s).

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.
Patients may request to receive confidential communications of their protected health information (PHI) from Larson Family Chiropractic. A patient may request that communications from the practice be sent to an alternate location or by an alternate means. Larson Family Chiropractic will accommodate reasonable requests for such confidential communications. The patient is not required to give a reason for this request. If disclosing information through regular channels will endanger the patient, he/she may want to make that known to you.
Larson Family Chiropractic prefers these requests be in writing.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

You will be asked to provide a signed acknowledge of receipt. You agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA. **Covered Entity will provide patient with a copy of this authorization.**

For more information, to report a problem, or if you have questions and would like additional information, you may contact our practice's Privacy Official.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office of Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint with ether the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights-
U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Room 5009 F, HHH Building
Washington DC, 20201

PLEASE SIGN HERE _____