LaVista CHIROPRACTIC & WELLNESS CENTER

Case History Form

Date	Time

Welcome! Our mission is to love, serve, and empower individuals, families and future generations to experience a greater level of health through chiropractic care and a wellness lifestyle. We are committed to helping our practice members achieve their goals today, tomorrow and for a lifetime by becoming an active participant in their own well-being. To help us serve you better, please complete the following information.

Personal Information

Name: ____ **DOB:** ____/_____/_____ **Gender** (circle): M F
(Legal First) (Middle Initial) (Legal Last)

Address: ____
(Street) (City) (State) (Zip)

Home Phone Number: __________________ Cell **Number:** ___________________ **Work Number:** __________________
Is it ok to call you at work? O Yes O No

Relationship Status (circle one): Married/Single/Widowed/Divorced/Other

Social Security #: _______ - ______ - _________ **Email:** ____

Employer Name: __________________ **Work Status** (circle one): Employed/Student/Retired/Homemaker/Unemployed/Disabled
Type of Work/Work Duties: ____

Who may we thank for referring you to our office? O Family Member/Friend: _________________ O Other:________________

Past Health Information

Previous (Event and Approximate Date): O Motor Vehicle Accidents____

O Childhood Traumas_____________________________ O Childhood Illnesses ________________________________
O Sports Injuries ________________________________ O Major Injuries/Falls ________________________________
O Work Injuries _________________________________ O Emotional Traumas ________________________________
O Broken Bones_________________________________ O Cancer ____
O Illness_______________________________________ O Major Strains/Sprains: _____________________________
O Hospitalizations_______________________________ O Other: ____

Major Surgeries/Operations: O Appendectomy 0 Tonsillectomy 0 Gall Bladder 0 C-Section 0 Hernia Repair 0 Hysterectomy
O Pacemaker 0 Back/Neck Surgery_______________ 0 Joints Replaced_______________ O Other: ______________________

Family Health History (List Relationship): O Diabetes ________________________ 0 Cancer _________________________
O Heart Disease _____________________ O Stroke ___________________________ 0 Thyroid ________________________
O Psychiatric ________________________ O Other: _______________________________________

Have You Had Previous Chiropractic Care? (__) No (__) Yes, please provide: Dr.'s Name:____________________________
Clinic Name/Location_____________________________ Date of Last Visit ________ Reason for Visit: __________________

Family/Primary Physician: Dr.'s Name: _______________________________________ Date of Last Visit**:** ________________
Clinic Name/Location________________________________ Reason for Visit: ___________________________________

Vitamin/Supplement/Medication Name (Please provide a list if available)	Amount Taken (mg)	How Long I've Been Taking It	Reason for Vitamin/Supplement/Medication

Lifestyle	Often	Occasionally	Never	In the Past
Smoke/use tobacco?	O	O	O	O
Drink alcohol?	O	O	O	O
Play adult sports?	O	O	O	O
Drink caffeine?	O	O	O	O
Computer/tv use?	O	O	O	O

Rate the following as Poor, Good, Excellent

Diet:	Poor	Good	Excellent
Exercise:	Poor	Good	Excellent
Sleep:	Poor	Good	Excellent
Water Intake:	Poor	Good	Excellent

On a scale of 1-10 describe your stress level: (1 = none/ 10 = extreme) Occupational _______ Personal _______

Have you had trouble with any of the following?

Cardiovascular	Have	Had	None
Poor Circulation	O	O	O
High Blood Pressure	O	O	O
Low Blood Pressure	O	O	O
Aortic Aneurysm	O	O	O
Heart Disease	O	O	O
Vascular Disease	O	O	O
Heart Attack	O	O	O
Chest Pain	O	O	O
Irregular Heartbeat	O	O	O
Swelling of Legs/Ankles	O	O	O

Genitourinary	Have	Had	None
Kidney Disease	O	O	O
Lower Side Pain	O	O	O
Burning with Urination	O	O	O
Frequent Urination	O	O	O
Blood in Urine	O	O	O
Kidney Stone	O	O	O
Incontinence	O	O	O
Urinary Infection	O	O	O

Hematologic/Lymphatic	Have	Had	None
Hepatitis	O	O	O
Blood Clots	O	O	O
Easy Bruising	O	O	O
Easy Bleeding	O	O	O
Fevers/Chills/Sweats	O	O	O

Respiratory	Have	Had	None
Asthma	O	O	O
Shortness of Breath	O	O	O
Emphysema	O	O	O
Bronchitis	O	O	O
Cold/Flu	O	O	O
Persistent Cough	O	O	O

Ears/Nose/Throat	Have	Had	None
Hearing Loss	O	O	O
Sinus Infection	O	O	O
Loss of smell/taste	O	O	O
Difficult Swallowing	O	O	O
Bleeding Gums	O	O	O
Frequent Ear Infections	O	O	O

Eyes	Have	Had	None
Glaucoma	O	O	O
Cataracts	O	O	O
Double Vision	O	O	O
Blurred Vision	O	O	O

Integumentary	Have	Had	None
Skin Lesions/Rashes	O	O	O
Eczema	O	O	O
Psoriasis	O	O	O
Skin Cancer	O	O	O

Constitutional	Have	Had	None
Sudden Weight Loss/Gain	O	O	O
Unexplained Fatigue	O	O	O
Difficulty Sleeping	O	O	O

Psychiatric	Have	Had	None
Depression	O	O	O
Nervousness/Anxiety	O	O	O
Unusual Stress	O	O	O

Other: ____________________________________

Immunologic	Have	Had	None
Immune Disorder	O	O	O
HIV/AIDS	O	O	O
Seasonal Allergies	O	O	O

Gastrointestinal	Have	Had	None
Gallbladder Problems	O	O	O
Bowel Problems	O	O	O
Constipation	O	O	O
Diarrhea	O	O	O
Liver Problems	O	O	O
Ulcers	O	O	O
Nausea/Vomiting	O	O	O
Bloody Stools	O	O	O
Poor Appetite	O	O	O
Heartburn	O	O	O
Food Allergies: ___________	O	O	O

Musculoskeletal	Have	Had	None
Arthritis	O	O	O
Joint Stiffness	O	O	O
Muscle Weakness	O	O	O
Difficulty Walking	O	O	O
Osteoporosis/Bone Loss	O	O	O
Neck Pain	O	O	O
Back Pain	O	O	O
Jaw/TMJ Problems	O	O	O
Hip Pain/Stiffness	O	O	O
Scoliosis	O	O	O
Knee injuries	O	O	O
Foot/ankle pain	O	O	O
Shoulder problems	O	O	O
Elbow/wrist pain	O	O	O
Poor posture	O	O	O

Endocrine	Have	Had	None
Hypothyroidism	O	O	O
Hyperthyroidism	O	O	O
Excessive Thirst	O	O	O
Hot Flashes	O	O	O

Neurological	Have	Had	None
Dizziness/Vertigo	O	O	O
Seizures	O	O	O
Tremors	O	O	O
Head Injury	O	O	O
Headaches/Migraines	O	O	O
Fainting	O	O	O
ADHD/ADD/Autism	O	O	O
Pinched Nerves	O	O	O
Carpal Tunnel	O	O	O
Loss of Balance/Coordination	O	O	O
Tingling/Numbness in arms/hands/fingers/legs/feet/toes	O	O	O

Reproductive	Have	Had	None
Menstrual Pain	O	O	O
Menstrual Irregularity	O	O	O
Fertility Problems	O	O	O
Prostate Dysfunction	O	O	O
Sexual Dysfunction	O	O	O
Endometriosis	O	O	O
Polycystic Ovarian Syndrome	O	O	O

FEMALES ONLY:

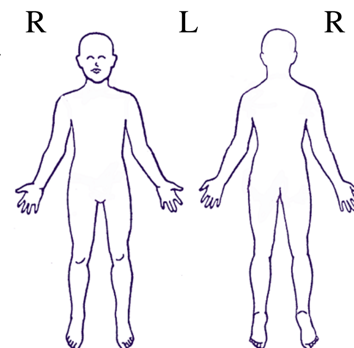
Date of your last period? ____________________

Are you or is there a possibility that you are pregnant? O Yes O No

Are you trying to become pregnant? O Yes O No

Please tell us what brought you into our office today: (check one) O Wellness: please skip to the next page.
O Health challenge/condition: please provide details below. O Injury: please provide details below.

• Health Challenge/Condition #1:



Please describe your primary health challenge: ____
____

What accidents/events/activities do you think are the cause?___________________________

When did it start? # Days ago_____ # Weeks ago______ # Months ago_____ # Years ago_____

Circle on the diagram the location of the health challenge/condition→

What makes it better? (time of day, movements, activities, etc.):___________________________
____

What makes it worse?: ____

How would you describe the amount of time that you experience the health challenge?
Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

How often does it occur? O Daily (# per day ____) O Weekly (# per week ____) O Monthly (# per month ____)

Type of pain: Achy/ Burning/ Cramping/ Dull/ Numbness/ Sharp/ Shooting/ Stabbing/ Stiffness/ Swelling/ Throbbing/ Tingling

Location of any numbness/tingling/radiating symptoms: ____

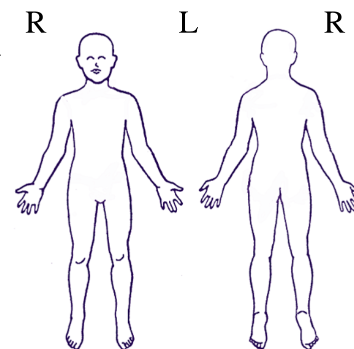
Severity of Discomfort (0 = No Discomfort, 10 = Severe Discomfort): 0 1 2 3 4 5 6 7 8 9 10

List any daily activities/functions that are limited or difficult because of the discomfort. (i.e.: concentration, work, sleeping, bending, sitting, turning, lifting)____

Prior interventions: (What have you done to relieve the symptoms?)
O Prescription medication O Over-the-counter drugs O Chiropractic O Massage O Pain Specialist O Other: _______________

Any MRI/CT/Xray Studies performed? (__) No (__) Yes, please provide: Date:__________ Clinic Name/Location:______________

• Health Challenge/Condition #2 (if applicable):



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Any MRI/CT/Xray Studies performed? (__) No (__) Yes, please provide: Date:__________ Clinic Name/Location:______________

Overall Health Assessment:

1) **Is there anything that you are limited in being able to do in your life as a result of your health condition?**

____

____

2) **In addition to the main reason for your visit today, what additional health goals do you have?**

____

____

Activities of Daily Living: How does this condition currently interfere with your ability to function? (please check)

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting				
Rising out of a chair				
Using a computer				
Standing				
Walking				
Lying down				
Bending over				
Climbing stairs				
Driving a car				
Looking over shoulder				
Caring for family				

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping				
Household Chores				
Lifting objects				
Reaching overhead				
Showering or bathing				
Dressing myself				
Getting to sleep				
Staying asleep				
Concentrating				
Exercising				
Yard work				

How do you plan to pay for care? (Please check one)

O Personal Insurance. Health Insurance Company name: Primary:_______________________

Secondary:_______________________ Insured's Name: _____________________________ Insured's DOB: ___/___/______

Insured's SSN#: ______ - _____ - _______

O Third Party Insurance. Insurance Company name:____

O No Insurance, Self-pay

Financial Policy: I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I authorize assignment of my insurance benefits (if applicable) directly to the provider for services rendered and any amount authorized to be paid will be credited to my account upon receipt. 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 that fees for professional services will become immediately due upon suspension or termination of my care or treatment and if payment is not collected in a timely manner I may be subject to collections means and/or interest payments of 12%. It is understood that the amount paid for x-rays is for examination only and the originals remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Informed Consent for Treatment: I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I hereby authorize this office and its staff to examine and treat my condition, as he or she deems appropriate. I understand that ultimately it is my decision to proceed with any instructions given by my doctor. As with any healthcare problem, there are certain complications that may arise during chiropractic adjustments and therapy. Soreness similar as to what is experienced following exercise is common. Dizziness, fractures/joint injury may occur but are relatively rare. Nerve damage or stroke is reported to occur once in one million to once in ten million adjustments (comparable to your chance of getting hit by lightning). Your chiropractor will make every reasonable effort to screen for complications of care; but if you have a condition that would not otherwise come to the doctor's attention, it is your responsibility to inform our office. Other treatment options may include: self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitalization and surgery. If you choose one of these options listed you should be aware that there are risks and benefits of such options. The risks and dangers of remaining untreated: may allow formation of adhesions (reduce mobility) which may prolong recovery and effectiveness of treatment.

Consent for Use and Disclosure of Protected Health Information: La Vista Chiropractic & Wellness Center (LVC) is required by law to protect individual's privacy, provide a notice of its privacy practices, and abide by the terms of the current notice. I have the right to review the Privacy Practices for a more complete description prior to signing this consent. A revised notice of Privacy Practices may be obtained by forwarding a written request to LVC. I have the right to contact Human & Health Services (HHS) and/or Dr. Lindsey Lofstedt (Snyder) at LVC if I believe my privacy rights have been violated. I may revoke my consent in writing except to the extent that LVC has already made disclosures in reliance upon prior consent. If I do not sign this consent, the doctors at LVC may decline to provide treatment to me. I have the right to request that LVC be able to disclose my protected health information (PHI) to person's involved in my health care or payment of health care. By signing this form, I am consenting to the use by LVC of my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I grant the use of my signed statement of authorization with my signature for required insurance submissions. With my consent, LVC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders. Also, with my consent, LVC may send mail to my home involving any TPO (marked personal and confidential). Please be advised that our treatment area is an open environment. We respect the right for privacy. Please inform us if you have an issue which needs to be discussed in private.

***Do you have any questions regarding informed consent, our financial policy, or our privacy policy? (__) No (__) Yes, please explain:____ CA/Dr. Initial: _____**

***Patient or Legal Guardian Signature: _________________________________ Date: ______________**