LALONDE CHIROPRACTIC CLINIC – NEW PATIENT FORMS

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Patient First Name _____ M.I. ____ Last _____ ❑ Female ❑ Male

Address _____ City _____ State _____ Zip Code_____

Phone (_____) _____-_____ 2nd Phone (_____) _____-_____ Age _____Date of Birth _____/_____/_____

Insured Person's Name _____ Insured I.D. or SSN _____

Employer Name _____ Insurance Company _____ Group Plan No. _____

Do you have other insurance? ❑ Yes ❑ No Please list _____

Is your illness or injury related to: ❑ Work ❑ Auto ❑ Other_____

PLEASE LIST YOUR REASON(S) FOR THIS VISIT OR YOUR CONDITION(S) IN ORDER OF IMPORTANCE:		
1.	*Date of Onset:*	*How much of the time do you feel pain:* ❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100%
Please mark how your condition happened: ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto Accident ❑ Other _____		*Using a scale in which "0" is no pain and "10" is severe, circle the number that best reflects your condition:* 0 1 2 3 4 5 6 7 8 9 10
*Check if your condition is **better** with the following:* ❑ Heat ❑ Cold ❑ Rest ❑ Activity ❑ Other _____	*Check if your condition is **worse** with the following:* ❑ Heat ❑ Cold ❑ Rest ❑ Activity ❑ Other _____	
2.	*Date of Onset:*	*How much of the time do you feel pain:* ❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100%
Please mark how your condition happened: ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto Accident ❑ Other _____		*Using a scale in which "0" is no pain and "10" is severe, circle the number that best reflects your condition:* 0 1 2 3 4 5 6 7 8 9 10
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3.	*Date of Onset:*	*How much of the time do you feel pain:* ❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100%
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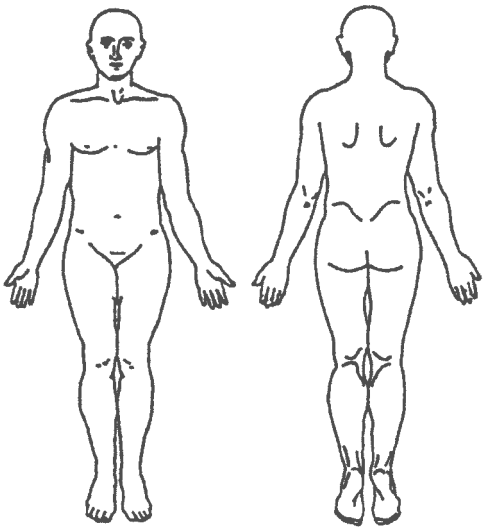

Please mark the areas of discomfort or pain on the figures above using the symbol that best describes the feeling:

A	Aches
B	Burning
N	Numbness
O	Other Symptoms
+++	Sharp or Stabbing
ooo	Pins and Needles

Please check the box that best describes whether your pain or symptom(s) limit normal activities:	NORMAL	SOMEWHAT LIMITED	SEVERELY LIMITED
ACTIVITY:			
Lifting			
Bending			
Standing			
Walking			
Sitting			
Climbing Stairs			
Running			
Resting in Bed			
Intercourse			
Computer Work / Typing			
Normal Work			
Household Activities			
Recreational Activities			
Other			

What time of the day do you feel the worse? _____

Do you sleep well? ❑ Yes ❑ No What are your normal sleeping hours? _____ to _____

Are you currently under the care of a medical doctor or other type of health care provider for any condition?

❑ Yes ❑ No If yes, for what condition _____

Name of doctor / provider _____ Phone number _____

Have you ever had an overnight stay in a hospital or a surgical procedure of any kind? ❑ Yes ❑ No

Event _____ Year _____

Event _____ Year _____

Event _____ Year _____

Event _____ Year _____

Do you exercise? ❑ Yes ❑ No If yes, describe activity _____

How many days a week? _____ How many minutes per session? _____

PERSONAL HISTORY

Please check the box next to each condition that applies to you.

PAIN IN BODY

- ❑ Neck pain with difficulty swallowing
- ❑ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ❑ Leg pain that worsens with exercise but is relieved by resting
- ❑ Loss of feeling in inner thighs
- ❑ Back pain with urinary problems

TYPES OF PAIN

- ❑ Severe pain interrupts sleep
- ❑ Constant pain that doesn't improve by changing positions or lying down

CURRENT CONDITIONS

- ❑ Unable to balance when walking
- ❑ Recent unexplained weight loss
- ❑ Recent progressive muscle weakness or shaking
- ❑ Recent or current fever over 102 degrees
- ❑ Loss of bowel or bladder control
- ❑ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ❑ Recent major accident such as a fall from height, whiplash or blow to the head
- ❑ Memory loss after injury

PREVIOUSLY DIAGNOSED CONDITION / MEDICAL HISTORY

- ❑ Congenital bone or joint disorder
- ❑ Rheumatoid arthritis
- ❑ Severe degenerative arthritis
- ❑ History of compression fracture
- ❑ History of heart attack
- ❑ History of stroke or aneurysm
- ❑ Past history of cancer or currently diagnosed with cancer
- ❑ Diabetes with cold, burning or numb feet
- ❑ Gout
- ❑ Lupus
- ❑ Ankylosing spondylitis
- ❑ Immune suppression such as a from chemotherapy, organ transplant, etc.
- ❑ Three or more months use of steroid medications or intravenous drugs (past or recent)
- ❑ Other (please list below)

_____

_____

_____

_____

FAMILY HISTORY

Please check the box next to each condition that applies to your family history.

❑ Autoimmune Disorders	❑ Cancer	❑ Heart Disease	❑ Mental Illness
❑ Arthritis	❑ Diabetes	❑ Kidney Disease	❑ Seizure Disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's Date _____/_____/_____

If patient required assistance to compete this form, please sign below and state relationship (i.e. parent, translator):

Signature _____ Relationship _____

AUTHORIZATIONS AND RELEASES

Please read the following sections, initial that you have read each section and sign this form to authorize treatment.

Patient Health Information and Privacy Policy **Initial** _____

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available online at https://www.hhs.gov/hipaa.

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations. Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the items of this policy.

Consent to Professional Treatment **Initial** _____

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child and grant my consent for the treatment of the child as provided herein. The patient may refuse treatment at any time.

Consent to Perform and Interpret X-rays **Initial** _____

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no know limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Assignment of Benefits and Release of Records **Initial** _____

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Financial Obligation and Appointment Policy **Initial** _____

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advance notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges when incurred.

Signature _____ Date _____

COVID-19 PRE-SCREENING

1. Have you come into close contact (within 6 feet) with someone who has a laboratory confirmed COVID-19 diagnosis within the past 14 days?

   NO YES explain _____

2. Are you a first responder, health care worker or employee of an adult care facility?

   NO YES explain _____

3. Are you experiencing a fever or have you experienced a fever in the last 48 hours?

   NO YES explain _____

4. Do you have shortness of breath?

   NO YES explain _____

5. Are you coughing more than normal?

   NO YES explain _____

6. Do you have a sore throat?

   NO YES explain _____

7. Have you lost any sense of taste or smell?

   NO YES explain _____

8. Do you have muscle aches, fatigue or diarrhea?

   NO YES explain _____

9. Have you been diagnosed with COVID-19?

   NO YES explain _____

10. Have you been tested for COVID-19 antibodies?

    NO YES explain _____

COMPLETE IF APPLICABLE

PLEASE COMPLETE IF YOU ARE FEMALE

NON-PREGNANCY VERIFICATION

I hereby state that I am, of this date, not pregnant or think that I am, and that I, release LaLonde Chiropractic Clinic, of any and all responsibility of liability regarding the above statement.

Signature _____ Date _____

PLEASE COMPLETE IF YOUR MINOR CHILD IS SEEKING TREATMENT

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Russell J. LaLonde, D.C. to administer treatment as He deems necessary

to my Son/Daughter _____

Signature _____ Date _____

Witness _____