LUCAS
CHIROPRACTIC & ACUPUNCTURE

CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI)_____ **Preferred Name**: _____

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

Home Phone:_____ **Mobile**:_____ **Work**: _____

Email:_____ **Gender**: M / F **Marital Status**: Married / Single / Other

Date of Birth:_____ **Occupation:**_____ **Employer:**_____

Referred by *(name)*: _____

☐ **Family** ☐ **Friend** ☐ **Co-Worker** ☐ **Doctor** ☐ **Other:**_____

-CMS requires providers to report both race and ethnicity-

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**:_____

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name:_____ **Preferred Contact Number**:_____

Relationship: Child / Parent / Spouse / Other: _____

Primary Care Physician:_____ **Doctor's Phone**: _____

FINANCIAL INFORMATION -- ***Please allow us to photocopy your insurance card.***

Self Pay (Cash) **Insurance** **Personal Injury/Auto** **Other (please explain)** _____

PRIMARY INSURANCE:_____ **SECONDARY INSURANCE**:_____

Policy Holder:_____ **Policy Holder**:_____

Relation to Insured: Self / Spouse / Parent / Child / Other **Relation to Insured**: Self / Spouse / Parent / Child / Other

Policy Holder DOB: _____

Patient Name: _____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

What brings you here today: _____

When Did This Episode Start (date): _____ **What Event Caused It:** _____

If this is NOT the first time, how long has this been a recurring problem? _____

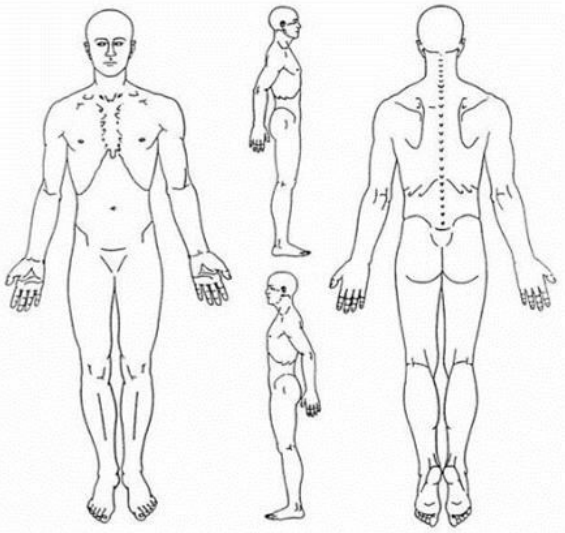
Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

The Complaint is: Constant / Comes and Goes

Is The Complaint: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Pins and Needles Other: _____

Does It Radiate/Shoot To Any Areas Of Your Body? No / Yes **If YES, where:** _____

DRAW AREAS OF COMPLAINTS:



What Makes It Better? Ice / Heat / Rest / Movement / Stretching / OTC Meds / RX Meds / Chiropractic

What Makes It Worse? Sit / Standing / Walking / Lying down / Sleeping / Movement

Who Else Have You Seen For This? No One / DC / MD / PT / Massage / ER / Other: _____

- Where: _____

Diagnostic Tests: None / X-rays / MRI / CT / Other: _____ **When and Where:** _____

Any Other Complaints: _____

Patient Name: _____

Does anyone in your IMMEDIATE family have a history of (circle condition): ☐ **NONE**

Heart Disease If yes, who_____ **Stroke** If yes, who _____

Cancer If yes, who_____ Type_____ **Other Relevant Family History**:_____

PAST HEALTH HISTORY: (List even if it was 20 years ago…)

Injuries, Traumas or Hospitalizations: ☐ **NONE** _____

Surgeries – Date, Type and Reason: ☐ **NONE** _____

Current Medications: ***Did you bring a list? Can we make a copy?*** ☐ **NONE** _____

Allergies to Medications: *(List and reactions)* ☐ **NONE**

_____

Vitamins & Supplements: *(List all and frequency)* ☐**NONE**

_____

Are you ***CURRENTLY*** experiencing any of these symptoms? (Check all that apply)

General:
- ❑ Recent Intentional Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Broken Bones
- ❑ Muscle Spasms/Cramps
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Have you ever had a head injury?
- ❑ Had an auto accident? Year:_____
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat Changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Tobacco Use
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Wear Contacts/Glasses
- ❑ Blurred or Double Vision
- ❑ Eye Disease or Injury
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Cold Extremities
- ❑ Heat or Cold Intolerance
- ❑ Immune System Disorder
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Non-healing Sores
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ *None in this Category*

Genitourinary:
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Urinary Leakage or Bed Wetting
- ❑ Blood in Urine
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes-Due Date: _____
- ❑ No-Last Menstrual Period: _____
- ❑ Painful or Irregular Periods
- ❑ Urine Leakage with Coughing or Sneezing
- ❑ Urine Leakage with Laughing or Lifting
- ❑ *None in this Category*

Pregnancies with Outcome & Date

_____

_____

Other Conditions not listed:_____

Is there anything else you would like the doctor to know?

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature_____ Date_____

Doctor Signature_____ Date _____

Functional Rating Index

In order to properly assess your condition, we must understand how much your symptoms have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Severely Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain; No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need assistance	Severe Pain Need 100% Assistance

4. Travel (driving, etc.)

0	1	2	3	4
No Pain on long trips	Mild pain on long trips	Moderate Pain on long trips	Moderate Pain on short trips	Severe Pain on short trips

5. Work

0	1	2	3	4
Can do usual work Plus extra work	Can do usual work No extra work	Can do 50% of Usual work	Can do 25% of Usual work	Cannot Work

6. Recreation

0	1	2	3	4
Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activites

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain 25% of day	Intermittent Pain 50% of day	Frequent Pain 75% of day	Constant Pain 100% of day

8. Lifting

0	1	2	3	4
No Pain with heavy weight	Increased Pain with heavy weight	Increased Pain with moderate weight	Increased Pain with light weight	Increased Pain with any weight

9. Walking

0	1	2	3	4
No Pain Any Distance	Increased Pain After 1 mile	Increased Pain After ½ mile	Increased Pain After ¼ mile	Increased pain With All Walking

10. Standing

0	1	2	3	4
No Pain After several hours	Increased Pain After several hours	Increased Pain After 1 hour	Increased Pain After ½ hour	Increased pain With Any Standing

Patient Signature _____ Date _____

Print Name _____ R11 R12 R13

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Notice of Privacy Practices

Lucas Chiropractic (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic X-rays on me (or on the patient named below, for whom I am legally responsible) by Matthew A. Lucas, DC and/or other licensed doctors of chiropractic who now or in the future work at Lucas Chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks but the information is provided so that I may make an informed decision.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to fractures, disc injuries, VBA, 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or Guardian Signature_____ Date _____

Print Name *(First MI Last)*_____ Account # _____

DO NOT WRITE IN THIS BOX

Patient Accepted?	YES	NO	Doctor's Signature _____

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