Landrum Spine and Sport Chiropractic			**Confidential Patient History**
130 Hammond Drive	Hopkinsville, KY 42240	Phone: (270) 886-3136	Website: www.landrumdc.com

Date: _____/______/_______

Patient's Full Name ____

Mailing Address: _____________________________________ City: ______________ State:_____ Zip:__________

Home Phone: ______________________ Cell Phone: ____________________E-Mail: __________________________

Date of Birth: _____/____/______ ☐ Male ☐ Female

Social Security # ________ - ________ - ________

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

- Spouse's Name: ___________________________________

Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed

Occupation: ______________________________

- Employer:__________________________

Family Physician: __________________________ City: ____________________ State: __________

Previous Chiropractic Care: ☐ Yes ☐ No

- If Yes, for What? ______________________________________
- Chiropractor's Name: ___________________________________

Referred by (Friend, Relative, Physician or Other Media) :_________________________

Type of care you interested in: ☐Pain relief only ☐Healing of current condition ☐Optimizing your health ☐**All three**

What is your long-term goal from treatment (e.g. play a round of golf without pain)? ______________________________

Is Today's Visit Due To An Work Related Injury: ☐ Yes ☐ No

Is Today's Visit Due To An Auto Accident: ☐ Yes ☐ No

(If yes to either questions above, please check with receptionist, additional information is needed)

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you**.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Landrum Spine and Sport Chiropractic) are **paid in full**.

Patient Signature___________________________________ Date______/_______/___________

Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem before for which you are consulting us: ☐ Yes ☐ No
   - If Yes, When: ____
   - Was treatment provided: ☐ Yes ☐ No
   - Outcome: ____

2. Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No

3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No

4. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, surgeries?** ☐ Yes ☐ No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

SYSTEMS REVIEW QUESTIONS:

Do you or have you ever had any problems with the following areas? (Please mark **Y** for yes or **N** for no in each of the following)

1. _____ Headaches
2. _____ Ears, Nose, Mouth, Throat
3. _____ Heart
4. _____ Lungs/ Breathing
5. _____ Intestines/Bowels
6. _____ Urinary
7. _____ Muscles
8. _____ Nerves
9. _____ Joints/Bones
10. _____ Skin
11. _____ Internal Organs
12. _____ Blood
13. _____ Allergies
14. _____ Psychological/Emotional

Females only:

15. _____ Gynecological/Menstrual/Breast

Males Only:

17. _____ Prostate/Testicular/Penile

Please explain **Yes** answers

____
____
____
____
____

SOCIAL HISTORY:

Recreational Activities (Hobbies):____

Yes	No		
☐	☐	Do you exercise? ________________	Times per week
☐	☐	Do you smoke? ________________	Packs per day
			If you quit smoking when did you quit? __________________
☐	☐	Do you use other forms of tobacco?	What how much per day? ______________________________
☐	☐	Do you consume alcohol?	How many drinks per week? ___________________________
☐	☐	Do you get adequate sleep?	If no, explain: ____
☐	☐	Is work stressful to you?	If yes, explain: ____
☐	☐	Is family life stressful to you?	If yes, explain: ____

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Chief complaint: ____

Secondary or related complaint(s) if any: ____________________________________

Date of Onset/ When did your symptoms begin? _________________________________

Was the Onset: ☐ Gradual ☐ Sudden

Since its' onset, has it gotten: ☐ Worse ☐ Better

Describe what caused the pain:____

Have you detected any possible relationship of your current complaint with any of the following:

☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory

☐ Other:________________________

Have you tried any self-treatment or medication (over the counter or prescription): ☐ Yes ☐ No

If yes, explain:____Results:_________________

What medications are you currently taking?____________________________________

Are you currently pregnant? ☐ Yes ☐ No

Are you currently taking anti-coagulant or blood thinning medication? ☐ Yes ☐ No

PAIN CHART

Please Mark Areas of Pain using these Codes

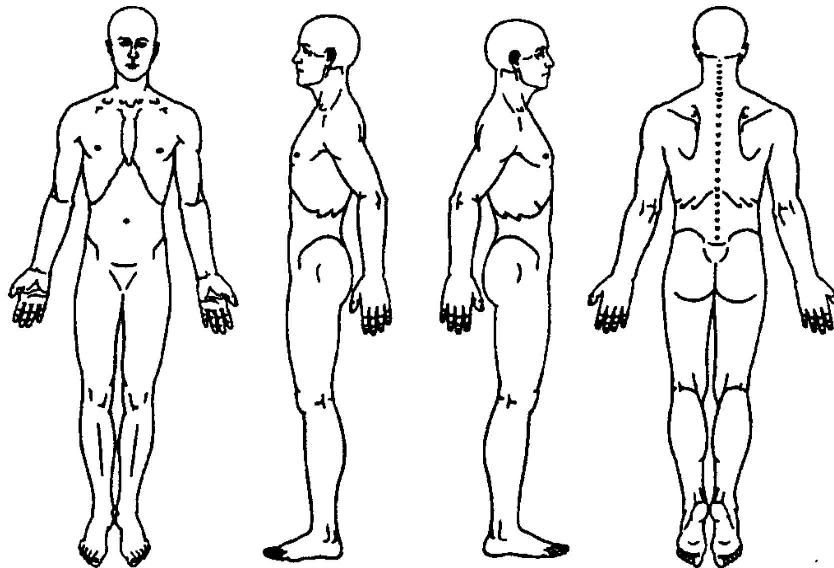
+++ Burning

Dull/Ache

*** Numbness/Tingling

=== Throbbing

000 Stabbing/ Sharp



SEVERITY OF PAIN

List region of pain and circle the number which represents the intensity of your pain

1. Complaint: _______________________ (**No pain) 0- 1 -2 -3- 4- 5- 6- 7- 8- 9- 10 (Unbearable pain)**
2. Complaint: _______________________ (**No pain) 0- 1 -2 -3- 4- 5- 6- 7- 8- 9- 10 (Unbearable pain)**

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows: Soreness/bruising, dizziness, fracture, stroke, joint injury and physical therapy burns.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

____ Signature of Patient Date______________________________

____Signature of Parent or Guardian (if a minor) Date______________________________

____Signature of Witness Date______________________________

Landrum Spine and Sport Chiropractic
Financial/Privacy Policy and Disclaimer

Insurance Verification

- **Insurance verification is not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.

Deductible Payments

- **It is our policy to collect at time of service a $30 fee.** Once we receive an "Explanation of Benefits" report form the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance

- Co-payments and Co-insurance is the patient's responsibility and will be **collected at the time of service.**
- If an "Explanation of Benefits" or EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. **Payment is due within 30 days** of receipt of the bill.
- In the event a bill is disputed, you **must notify use within 30 days**. If you do not notify us within that time, the bill will be presumed valid and due. In the event any further action is necessary to collect an unpaid bill, charges for the collection of delinquent accounts, including collection agency, court costs and or reasonable attorney's fees will be added to the total balance
- All balances remaining unpaid after 30 days, unless you have already worked out a payment plan with office manager, may be reported to a credit bureau and affect your credit rating.

Returned Checks

- It is our policy to **collect $25.00 for checks that are returned to us**. This is to cover any fees that apply from the transaction

Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a **$20 charge** added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

- We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator, Billie Utley.

HIPPA Privacy Policy

- Attached to the patient information packet at the back of these forms is the HIPPA Notice of Privacy Practices Policy for you.

- By signing below, the patient acknowledges that he/she has received the HIPPA Privacy Policy and that he/she understands and will comply with our financial policies.

__________________________ ________________

Patient Signature Date