Patient Information

Date:_____ **Last Name:**_____ **First Name:**_____

How did you hear about us?_____

SSN:_____ **Date of Birth:**_____ **Age:**_____ **Gender:** □ M □ F

Address:_____ **City:**_____ **State:**____ **Zip:**_____ **Marital Status**_____

Home or Cell Phone:_____ **Email:**_____ **# Children:**_____

Occupation:_____ **Employer:**_____ **Work Phone:**_____

Spouse's Name:_____ **Parent's Names (if you are under 18):**_____

Method of Payment Accepted: Cash, Check, Cards with Visa, Mastercard, Discover, American Express logo.

If you are a U.S. Military Active Duty/Veteran, please present your Militiary ID or DD214 to us for processing.

Any Changes/Cancellations to Appointment must be given 48 hours in advance to avoid a $45 office visit fee.

3 Consecutive No-Show Occurrences may terminate our relationship with you.

My goal for consulting w/ the doctor: ☐Temporary Relief ☐Lasting Correction ☐Doctor to recommend best care

Describe your major complaint:_____

_____

Timing: □ 0-25% □ 26-50% □ 51-75% □ 76-100%

When did your symptoms begin?_____ **Have you had similar symptoms in the past**? □Yes □No

How did your symptoms begin? □ Work Injury □ Auto Accident □ Other (describe):_____

*If from a personal injury or auto accident, please fill out Personal Injury Questionnaire

Progression (circle): □ Improving □ Not-Improving □ Worsening **What makes it worse?**_____

Describe: □ Sharp □ Shooting □ Achy □ Burning □ Numb □ Tingling **What makes it better?**_____

How severe are the symptoms on a scale of 1-10?(circle) NONE -1 2 3 4 5 6 7 8 9 10-WORST

In general, how would you rate your current overall health? □ Excellent □ Very Good □ Good □ Fair □ Poor

Has it affected your ability to work or do housework? □Yes □No How many days off from work/housework?_____

What activity would you like to be able to do again that is difficult or that you cannot do now?_____

What are your favorite hobbies or activities?_____ **Currently Affected?** □Yes □No

Have you been seen in past for? □ Chiropractic □ Acupuncture □ Nutrition □ Herbs □ Hilot

If yes, when?_____

Why did you see them?_____ Doctor/s Name?_____

What frequency was prescribed for your care?_____

When was your most recent set of spinal x-rays?_____

Have you had any MRI's or CT scans? □ Y □ N If yes, when and where?_____

Are you currently using/wearing foot orthotics? If so, are they custom made and fit to your feet? □ Y □ N

Who is your Primary Medical Physician? _____ Clinic name/Phone_____

When was your last set of medical tests: blood/ stool/ saliva/ urine?_____

HEALTH HISTORY - Please read through the list and check the box next to each condition that applies to you.

Last known: Height_____ Weight_____ Blood Pressure _____/_____(don't know)
Do you have an exercise routine? If so, please explain_____
Are you pregnant? □Yes □No
How is your diet?_____

Musculoskeletal - General

Now	Past	
□	□	Degenerative arthritis
□	□	Rheumatoid arthritis or Gout
□	□	Compression fracture
□	□	Osteomyelitis
□	□	Osteoporosis

Musculoskeletal Spine

Now	Past	
□	□	Poor Posture
□	□	Disc injury
□	□	Neck problem
□	□	Mid-back problem
□	□	Low back problem
□	□	Scoliosis
□	□	Ankylosing spondylitis
□	□	Difficulty swallowing because of neck pain
□	□	Pain or electric shocks in arms or legs on moving neck

Musculoskeletal Extremity

Now	Past	
□	□	Hip or Sacroiliac problem L/R
□	□	Leg, Knee, Ankle, Foot L/R
□	□	Shoulder problem L/R
□	□	Arm,Elbow,Hand problem L/R
□	□	Chest or Rib pain L/R

Nervous System

Now	Past	
□	□	Headaches or migraines
□	□	Tingling or numbness of arms, legs, hands or feet
□	□	Pinched nerve or sciatica
□	□	Poor balance
□	□	Depression or Anxiety
□	□	Difficulty dealing with stress
□	□	Dizziness or vertigo
□	□	Learning disorder or hyperactivity (ADD/ADHD)
□	□	Seizures/Epilepsy
□	□	Recent progressive muscle weakness or shaking
□	□	Numbness of inner thighs/groin

EENT

Now	Past	
□	□	Jaw, TMJ or mouth problem
□	□	Visual problems
□	□	Ear problems, infections or ringing
□	□	Chronic sinus problems
□	□	Face pain

GI/GU/Endocrine

Now	Past	
□	□	Abdominal pain
□	□	Constipation/Diarrhea
□	□	Heartburn/Acid Reflux/Ulcers
□	□	Uncontrolled Bladder or Bowel
□	□	Inflammatory bowel disease
□	□	Liver or gallbladder problems
□	□	Menstrual problems or PMS
□	□	Menopause symptoms
□	□	Difficulty getting/staying pregnant/other

Cardio-Pulmonary

Now	Past	
□	□	Pacemaker or implanted device
□	□	Breathing trouble or Asthma
□	□	High blood pressure
□	□	History of stroke or aneurysm

Medication-Related Issues

Now	Past	
□	□	Medication dependence
□	□	Drug or Vaccination reaction
□	□	Current drug side-effects
□	□	Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
□	□	3 or more months of steroid medications or intravenous drugs (past or present)

Injuries and General

Now	Past	
□	□	Car crash/whiplash injuries
□	□	Work injuries
□	□	Ergonomic stress at work
□	□	Sports injuries
□	□	Smoking habit: How much/day?_____
□	□	Drug/ Alcohol dependence
□	□	Psoriasis or psoriatic arthritis
□	□	Unexplained weight loss
□	□	Sleeping trouble
□	□	Get sick a lot/poor immune function
□	□	Fibromyalgia / Chronic fatigue
□	□	Tuberculosis, Hepatitis or HIV
□	□	Cancer or Tumor
□	□	Allergies:_____
□	□	Recent fever over 102°F
□	□	Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
□	□	Constant pain that doesn't improve by changing positions or by lying down
□	□	**OTHER HEALTH PROBLEM NOT LISTED**:_____

_____
_____

FAMILY HISTORY:

(circle any that apply)

Back problems - Back/neck surgery - Heart problems – Diabetes - Rheumatoid arthritis - High Blood Pressure - Cancer
Other:_____
_____

LIST ALL SURGERIES AND PROCEDURES YOU HAVE HAD:

_____
_____
_____
_____

LIST ALL MEDICATIONS/VITAMINS/ SUPPLEMENTS/HERBALS:

_____
_____
_____

LIST ANY TRAUMA'S, DATE, AND DESCRIPTION:

_____
_____
_____

CONSENT TO INITIATE CARE

Welcome to Luib Health Center. In order to provide for the most effective healing environment, most effective application of chiropractic/acupuncture and other office procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health. To that end, we ask that you acknowledge the following points regarding Chiropractic and Acupuncture care and the other services that are offered through this practice:

A. **Chiropractic & Acupuncture** are licensed health care disciplines which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery.
B. **The Practice of Chiropractic/Acupuncture** are Evidence-Based Practices. Chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. Acupuncture focuses on balancing energetic flow (qi) though energetic pathways (meridians).
C. **Chiropractic/Acupuncture evaluation and examination** is part of the standard chiropractic procedure. It is designed to identify health problems and chiropractic needs. Doctors of Chiropractic focus particular attention on prevention and correction of Subluxations. Acupuncturists integrate tongue and pulse diagnosis.
D**. Subluxation** (particularly of the spine and joints) is a complex of alignment, movement and/or pathological joint abnormalities that chokes off or compromises nerve integrity causing abnormal organ system function and ill health.
E. **Prevention of Subluxation** is accomplished through **maintenance adjustments** and nutritional, mental, and physical wellness habits taught and prescribed by Doctors of Chiropractic. Based on your condition, this office may also utilize adjunct therapeutic procedures as well.
F. **Chiropractic Adjustment** is a very specific manipulation, only performed by licensed chiropractors, to eliminate Subluxation and allow normal nerve function and health restoration. Chiropractic Adjustments are safe, effective procedures applied over one-million times each day in the United States alone.
G**. Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding or temporary bruising that usually resolves with pressure and arnica gel. It is normal for the patient to have a temporary warm, sore, or tingling sensation at the acupuncture site.
H. **Herbal Medicine/Teas/Nutrition Therapy/Supplement Protocols/Myofascial Therapy/ Home care** may be prescribed to augment treatment.
I. **We invite you to speak frankly to the doctor or staff** on any matter related to your care at our office. We work to maintain a supporting and open environment.
J. We do not seek to replace or compete with medical, dental or other type(s) of health professionals and will provide referral for other evaluation if the doctor feels it is the best interest of his patient. Those providers retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by other providers.
K. **Your Compliance** with your treatment schedules and instructions is essential to maximum healing and optimal health. We will work diligently to help you meet with any and all of your health needs.
L. **Cancellation Policy**: Your time is invaluable as is Dr. Luib's time. Your appointment time is reserved for you and we do our best to give you the care you deserve and need with minimal to no wait. Please give at least 48 hrs notice for cancelled or rescheduled appointments or a $45 office visit fee may be applied.

We are committed to providing the highest quality care possible so that you and your family may enjoy an active, healthy life, with affordable fees. Thank you for taking the first step towards restoring and maintaining your health.

I understand all of the above information and give consent for the Chiropractic/Acupuncture/Nutrition Evaluation and Myofascial Therapy to be performed by Dr. Luib and/or trained staff of the Luib Health Center.

Print Patient Name: _____

Patient or Guardian's Signature: _____ **Date:** _____

HIPPA Procedures and Authorization

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our office at 828-209-1900.

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information given to me and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. 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 and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ Date: _____

VIDEO/AUDIO/TESTIMONIAL RELEASE

In consideration of the opportunity to provide certain statements and participate in photography or audio/video taping relating to certain services/products of Luib Health Center. I agree to as follows:

1. I hereby consent to the recording of statements, photographs, and/or audio or video recordings taken of me by Luib Health Center and its staff.
2. All statements, photographs and/or audio or video recordings taken of me, by Luib Health Center may be used by Luib Health Center for promotional, commercial or other purposes as determined by Luib Health Center anywhere in the world in its sole discretion. I shall not have any right to control the use or publication by Luib Health Center of the statements, photographs, and/or audio or video recordings.
3. All statements, photographs, and/or audio or video recordings taken of me by Luib Health Center and its staff shall be the sole property of Luib Health Center and its staff. I shall not receive any compensation in connection with use of these statements, photographs, and/or audio or video recordings for promotional, commercial or other purposes.
4. I hereby release, waive and discharge any claims of any kind or nature arising out of or relating to the use of the statements, photographs, and/or audio or video recordings against Luib Health Center and its staff to publish said materials ("Publisher"), Such release, waiver and discharge shall also extend to all affiliated companies, shareholders, directors, officers, employees, and agents.
5. This release shall be binding upon me, and our respective successors, heirs, assigns, executors, administrators, spouse and next of kin.

I have read this document and I understand that I give up substantial rights on behalf of myself (including rights relating to publicity and privacy with respect to the commercial use of any statements, photographs, and/or audio or video recordings) and I sign this release freely and voluntarily.

Patient Signature: _____ Date: _____