Confidential Patient Health Record ***Today's Date*:____/_____/_____**

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Close to home/work ☐ Dr. _____ ☐ Advertisement ☐ Hospital ☐ Insurance Plan

Personal Information

Last:_____ First:_____ Middle: _____

Birth Date: ____ /____/_____ Age:_____ Sex: Male / Female Social Security #: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____Apt # _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ ext _____

Cell Phone: (_____) _____-_____ Fax #: (_____) _____-_____

Email Address: _____ Spouses Name: _____

Children (Names and Ages): _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Current Health Condition

Unwanted Condition (Why you are here today?):_____

_____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ☐ Yes ☐ No. When? _____

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

Explain: _____

_____

Date of Accident: _____

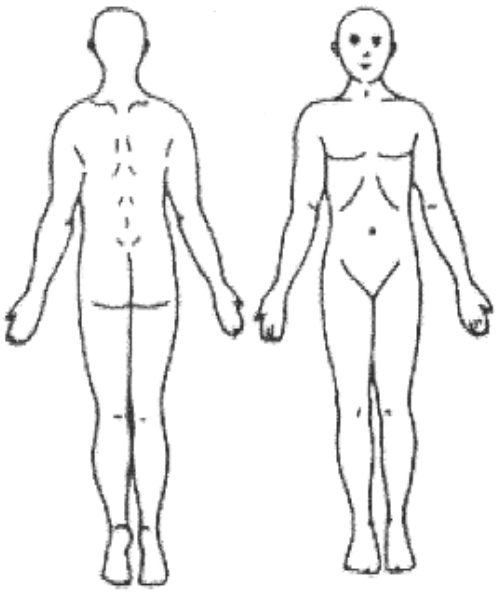
Time of Accident: _____ am /pm

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____
_____
_____
_____
_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

Key: A=Ache B=Burning N = Numbness P=Pins & Needles S=Stabbing



Condition: ☐ **New →** ☐ **Acute or** ☐ **Chronic**
☐ **Recurrence (Acute)** ☐ **Exacerbation (Acute)** ☐ **Chronic**

Description of Onset of Complaint: _____

Current Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Location: ☐ LEFT ☐ RIGHT ☐ Bilateral

Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other _____

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Timing: ***Worse*:** ☐ Morning ☐ Afternoon ☐ Night ☐ with Activity; ☐ Constant ☐ Intermittent

Context: ***Better with:*** ☐ Warm Temp ☐ Cold Temp ***Worse with:*** ☐ Warm Temp ☐ Cold Temp ☐ Damp

Assoc Signs and Symptoms: ☐ Blurred Vision ☐ Depression ☐ Dizziness ☐ Irritability/Mood Swing ☐ Localized Tingling ☐ Nausea
☐ Ringing in Ears ☐ Sleep Disturbance ☐ Stiffness

Radiation: ☐ **Left** ☐ **Right** ☐**Bilateral** **Weakness:** ☐ **Left** ☐ **Right** ☐ **Bilateral**

Other Assoc Signs and Symptoms: _____

Modifying Factors:

Symptoms Better With:

☐ nothing helps	☐ activity	☐ bending	☐ applying cold	☐ applying heat
☐ massage	☐ movement	☐ OTC meds	☐ Rx meds	☐ rest
☐ stretching	☐ sitting	☐ standing	☐ twisting	☐ walking

Symptoms Worse With: (as noted in Social History)

Since condition began, has anything permanently helped you? ☐ YES ☐ NO
Has anything that you have done, thus far, fixed your problem? ☐ YES ☐ NO

Employment:

Occupation/Job Title: _____ Work: _____ hrs / day or week

Description of Work: _____

Condition's Effect On Job Performance:

☐ **Mild** Painful (Can do) ☐ **Mod** Painful (limited ability) ☐ **Mod/Severe** Limited Duty ☐ **Severe** No Limited Duty ☐ **Severe** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform
Extended Computer use	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform
Reading -Concentration	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform
Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform
Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Severe** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____ ☐ **No Effect** ☐ **Mild** Painful (Can do) ☐ **Mod** Painful (Limited) ☐ **Severe** Unable to Perform
_____ ☐ **No Effect** ☐ **Mild** Painful (Can do) ☐ **Mod** Painful (Limited) ☐ **Severe** Unable to Perform

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

☐ **I have not previously seen a doctor for this condition OR Fill in the information BELOW**

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If yes, Who? (Name) _____
Type of Treatment: _____ Were you satisfied with the results of your treatment? ☐ Yes ☐ No

Explain: _____

Current Medication (s) and vitamins, minerals or herbs **- List ANY/ALL you are CURRENTLY taking. Be Specific.**

_____
_____
_____
_____

Injury (ies): **List All Injuries. Write the DATE of the Injury immediately afterward.**

_____
_____
_____

Non-Drug Allergies: **Please list any known non-drug allergies below.**

_____
_____

Adult Illness (es): **LIST all health conditions.**

_____
_____

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

_____
_____
_____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care. ***Check what may apply to you; if none apply, check the "I DENY" box.***

Constitutional (General): ☐ **I DENY having or have had any of the symptoms or problems listed below.**

☐ chills ☐ fever ☐ fatigue ☐ weight loss ☐ weight gain ☐ daytime drowsiness ☐ night sweats

Eyes/Vision: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ blindness ☐ eye pain ☐ change in vision ☐ field cuts ☐ photophobia ☐ itching
☐ blurred vision ☐ double vision ☐ glaucoma ☐ tearing ☐ cataracts

Ears, Nose and Throat: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ bleeding ☐ nasal congestion ☐ hearing loss ☐ nosebleeds ☐ sore throat
☐ dentures ☐ ear pain ☐ ear drainage ☐ history of head injury ☐ postnasal drip ☐ tinnitus
☐ difficulty swallowing ☐ fainting ☐ headaches ☐ hoarseness ☐ snoring ☐ rhinorrhea ☐ TMJ problems
☐ discharge ☐ frequent sore throats ☐ loss of sense of smell ☐ sinus infections ☐ dizziness

Respiration: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ asthma ☐ coughing up blood ☐ shortness of breath ☐ wheezing

Cardiovascular: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ angina (chest pain or discomfort) ☐ shortness of breath with exertion or exercise ☐ heart problems
☐ paroxysmal nocturnal dyspnea ☐ low blood pressure ☐ high blood pressure ☐ swelling of legs
☐ claudication (leg pain/ache) ☐ orthopnea (difficulty breathing lying down) ☐ ulcers ☐ varicose veins
☐ heart murmur ☐ palpitations

Gastrointestinal: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ abdominal pain ☐ diarrhea ☐ nausea ☐ indigestion ☐ abnormal stool caliber ☐ vomiting blood
☐ vomiting ☐ jaundice ☐ abnormal stool color ☐ hemorrhoids ☐ difficulty swallowing ☐ constipation

Endocrine: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ cold intolerance ☐ excessive hunger ☐ excessive thirst ☐ goiter ☐ diabetes ☐ unusual hair growth
☐ heat intolerance ☐ abnormal frequency of urination ☐ hair loss ☐ voice changes

Skin: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ changes in nail texture ☐ hair loss ☐ hair growth ☐ history of skin disorders ☐ skin lesions / ulcers
☐ changes in skin color ☐ hives ☐ itching ☐ rash ☐ paresthesias ☐ varicosities

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ dizziness ☐ limb weakness ☐ numbness ☐ slurred speech ☐ tremor
☐ facial weakness ☐ loss of consciousness ☐ seizures ☐ stress ☐ loss of balance
☐ headache ☐ loss of memory ☐ sleep disturbance ☐ strokes

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anhedonia ☐ loss or change in appetite ☐ behavioral change ☐ convulsions ☐ memory loss
☐ anxiety ☐ confusion ☐ insomnia ☐ bi-polar disorder ☐ depression ☐ mood change

Allergy: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anaphylaxis ☐ food intolerance ☐ acute nasal congestion ☐ chronic nasal congestion ☐ sneezing

Hematological: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anemia ☐ bleeding ☐ fatigue ☐ blood clotting ☐ bruising easily ☐ lymph node swelling

Male: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ burning urination ☐ frequent urination ☐ prostate problems ☐ urine retention
☐ erectile dysfunction ☐ hesitancy/dribbling

Female: ☐ **I DENY having any of the symptoms/problems and/or using any of the items listed below.**

☐ birth control ☐ cramps ☐ hormone therapy ☐ irregular menstruation ☐ vaginal bleeding
☐ breast lumps/pain ☐ frequent urination ☐ pregnancy ☐ urine retention ☐ vaginal discharge

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

father ☐ alive ☐ deceased ☐ normally developed ☐ no significant disease ☐ has/had:_____
mother ☐ alive ☐ deceased ☐ normally developed ☐ no significant disease ☐ has/had:_____

Social History: **Mark all that apply below.**

Alcohol: ☐ do not drink alcohol ☐ social consumption only ☐ drink the following regularly (mark below)
Quantity of _____ oz./glasses per ☐ day ☐ week ☐ month

Substance: ☐ never used illegal drugs ☐ has not used illegal drugs since _____ .
☐ never used IV drugs ☐ used illegal drugs for _____ (how long?)

Tobacco: ☐ Do not use ☐ Type_____ Amount_____

Insurance Information:

Do you have health insurance: ☐ NO ☐ YES Name of party responsible for payment: _____ Phone #: _____

PRIMARY Health Insurance Carrier: _____

Policy Holder's Name: _____ Relationship to you: ☐ SAME ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder's Date of Birth: ___ / ___ / _____ Subscriber ID #: _____ Group #: _____

SECONDARY / SUPPLEMENTAL Health Insurance Carrier: _____

Policy Holder's Name: _____ Relationship to you: ☐ SAME ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder's Date of Birth: ___ / ___ / _____ Subscriber ID #: _____ Group #: _____

AUTO ACCIDENT / WORKERS COMP *Additional information is needed; please complete Personal Injury / Worker's Comp forms*

☐ Auto Accident ☐ Work Related Injury

Insurance Company: _____ Contact Person / Attorney: _____

Phone #: _____ Claim #: _____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Living Tree Center for Healing will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Living Tree Center for Healing will be credited to my account upon receipt. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. As the patient I also agree that I am fully responsible for all bills incurred at this office. We are not a Medicaid Provider and do not accept Medicaid, any services incurred will be patient responsibility.

Patient Print Name: _____

Patient's Signature: _____ Date: _____

Parent/Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

SECTION A. INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments, Acupuncture and other chiropractic procedures, including various modes of physical therapy, massage and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic and/ or massage therapist who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor(s) or therapists of Living Tree Center for Healing and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments, Acupuncture and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are rare but possible risks to treatment, including but not limited to muscle soreness, pain, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications as all procedures carry some risk. 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) of which I seek treatment.

SECTION B. PRIVACY PRACTICE INFORMATION (HIPPA)

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows:

NAME: Nigel Brayer
ADDRESS: 11443 State Road
North Royalton, Ohio 44133
PHONE: (440)877-9440

PRACTICE'S REQUIREMENTS

The Practice is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

a) Under the Privacy Rule, may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided under federal law.
b) Is required to abide by the terms of this Privacy Notice.
c) Reserves the reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
d) Will distribute any revised Privacy Notice to you prior to implementation.
e) Will not retaliate against you for filing a complaint.

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notices of Privacy Practice,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or Disclosure that occurred prior to the date I revoke that consent is not affected.

EFFECTIVE DATE

This notice is in effect as of April 15, 2003.

SECTION C. POLICIES FOR PATIENTS

To help you receive our best, all patients are accepted for care based on the following policies by signing you agree to policies below:

- **Appointment Scheduling:** To save you time on each visit we ask that you pre-schedule your appointments in advance and that you refrain from repeatedly rescheduling appointments. In order to keep your progress on schedule, rescheduled appointments should be made up within 48 hours of the original scheduled time.

- **Broken Appointments:** There is a $15 fee for a missed or forgotten chiropractic appointment. To keep your progress on schedule, missed appointments should be made up within 48 hours. If you repeatedly miss or reschedule appointments or we must continually call you to reschedule, we will regretfully need to discharge you from our care. **Any massage, acupuncture or nutritional appointment that is not rescheduled or canceled with less than 24 hours notice, the total cost of appointment will still be owed.**

- **Financial Agreements:** It is your payment that allows us to continue providing high levels of professional care, maintain our facility and pay our staff. If for any reason you cannot keep your financial agreement, please inform us immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements. Balance in full must be paid upon dismissal unless other arrangements have been made. **A 5% service charge will be added monthly to any unpaid balance.**
  I understand if I purchase any prepaid or discounted services (these are services additionally discounted when prepaid) these will expire in 2 years from time of purchase. A refund can be requested within 14 days from the date

of purchasing a prepaid package, all refund requests must be made in writing within 14 days, after that all monies can be used towards services in the office **no refunds will be given**. I understand that after 2 years I forfeit any prepaid plan, or discounted treatment plan monies on my account.
I also understand that any additional treatments on my first visit beyond an evaluation and possible x-rays are an additional fee. This includes, a physical chiropractic adjustment, hot/cold therapy, exercise, Acupuncture, massage therapy or any supplements or additional services.

By my signature below, I have read and agree to the terms in the above sections A-C of the Living Tree Center for Healings' Confidential Patient Health Record forms, covering Living Tree Center for Healing's Informed Consent (Section A), Privacy Practice Information (HIPAA) (Section B) and Policies for Patients (Section C).

Patient Signature_____ Date _____

Parent / Guardian Signature _____ Date_____

Staff Initials: _____

OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

□ Individual refused to sign
□ Communications barriers prohibited obtaining that acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please Specify) _____

Date: _____ Initials: _____ Explanation: _____

VERIFICATION OF NON-PREGANANCY

Date: _____

Patient's Name: _____

Date of Birth: _____

By my signature on this form, I do herby state that, to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this particular time.

PATIENT SIGNATURE: _____

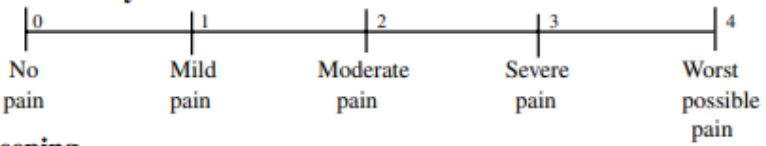
WITNESS: _____

Functional Rating Index

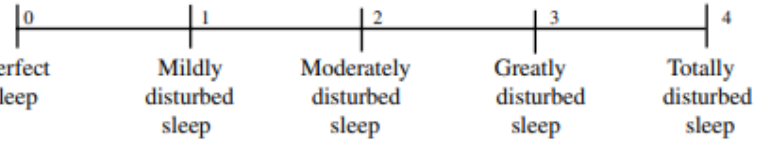
For use with **Neck and/or Back Problems** only.

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

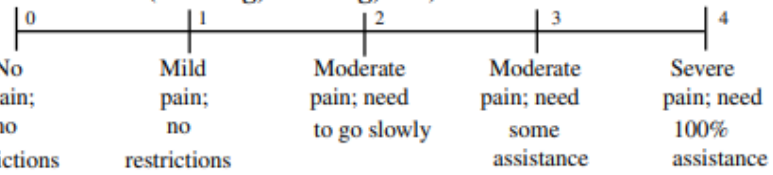
1. Pain Intensity



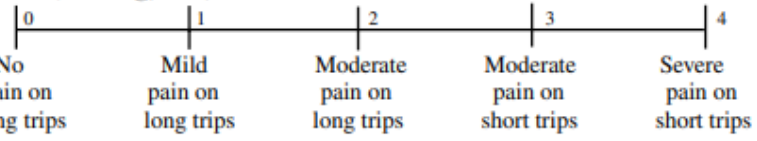
2. Sleeping



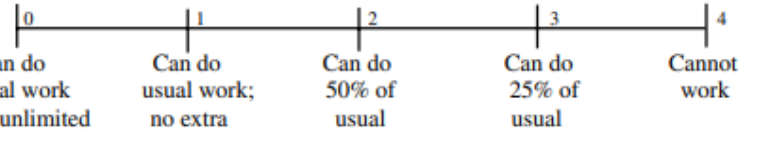
3. Personal Care (washing, dressing, etc.)



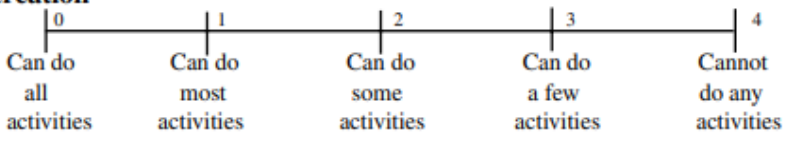
4. Travel (driving, etc.)



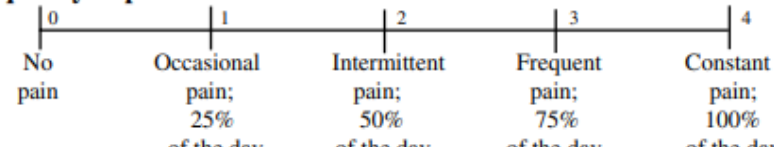
5. Work



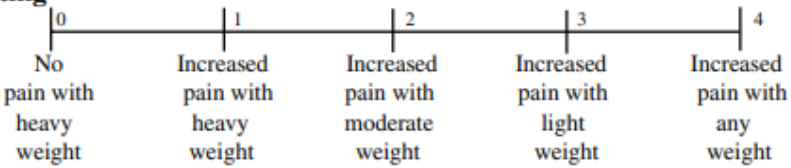
6. Recreation



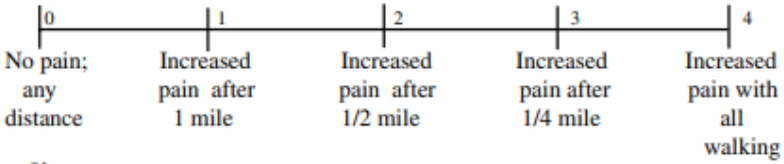
7. Frequency of pain



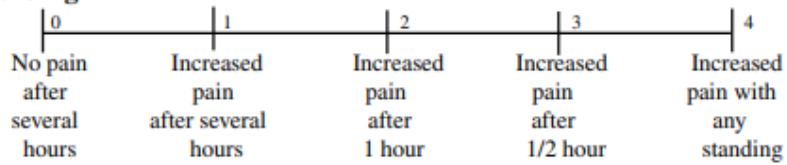
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date