Laufer Chiropractic
A Family Wellness Center
1810 Esplanade, Suite A
Chico, CA 95926

Confidential Patient Information

Full Name:_____ Date of Birth__/___/___ Age:____
Mailing Address:_____City_____ State_____ Zip_____
SSN:_____-_____-_____ Home Phone: (___)_____ Cell Phone(___)_____
Marital Status (_) Married (_) Single (_) Widowed (_) Divorced (_)Partnered for __ years
Date Symptoms Began:_____/_____/_____
Emergency Contact Name & Relationship:_____
Phone Number: (_____)_____
Employer's Name:_____ Occupation:_____
Work Address:_____ City_____ State_____
Work Phone Number (___)_____ Ext_____
Authorizations:

A. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts payment.
B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient / Guardian Signature: _____

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Acknowledgement of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the office of Dr. Laufer, detailing how my information may be used and disclosed as permitted under federal and state law.

Printed Name:_____

Signature:_____ Date:_____

Relationship:_____

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Informed Consent for Chiropractic Care Of a Minor without a Parent/Guardian Present

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on my minor child (for whom I am legally responsible) without my presence by the doctor of chiropractic named above and/or other licensed doctor of chiropractic who now or in the future work at the clinic or office listed above.

Child Name:_____**Date**_____

Print Name of Parent/Guardian:_____

Parent/Guardian Signature:_____

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Authorization and Consent Applied Kinesiology

During your course of care at Laufer Chiropractic, one of the techniques used will be Applied Kinesiology. This is a technique of muscle testing. Various muscle groups are evaluated to determine their strengths or weaknesses relative to the physical and postural problem you have at the time you enter the office.

Research done by Dr. George Goodheart has shown that there are five factors that can affect the muscle function. They are classified as: Nerve Supply, Neurolymphatic, Neuromuscular, Meridian, or Nutritional. They are often treated by stimulation, by hand or finger, on specific points on the body. There is a chart in each treatment room that depicts the location of these various points. Some of these areas may be considered sensitive i.e. the pubic area or the breast area. These procedures are done while the patient is fully clothed. The doctor will review the weakness in your particular case. If a sensitive area is involved you will be told before any procedure begins.

I have read this authorization and discussed Applied Kinesiology with Dr. Alex Laufer or his staff. I do consent to have this form of therapy used on me during the course of care for my current condition and any future conditions that I may have treated at Laufer Chiropractic.

Print Name:_____Date:_____

Signature:_____ Date_____

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Cancellation Policy

In an effort to serve you and our other patients more effectively, our office will be strictly enforcing our office cancelation policy.

A charge of $15.00 will be charged to your account for all missed appointments without at least 24 hours prior notification.

Should you have questions about this policy, please address your concerns to our front desk staff.

I have read and understand this policy.

Name:_____

Signature:_____

Date:_____

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Cash Payment Policy

This letter is written to familiarize you with the payment policy for our chiropractic office.

Payment is due in full at the end of each visit, unless a payment plan has been previously established.

Please sign and date below if you have read and understand this policy.

Printed Name:_____ Date:_____

Patient Signature:_____

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Child Name:_____**Date**_____

Print Name of Parent/Guardian:_____

Parent/Guardian Signature:_____

HEALTH QUESTIONNAIRE

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

Please use a **No. 2 pencil** to fill in your answers. When filling in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** this form.

Patient Name:

MO	DAY	YEAR
1 7 8 9 10 11 12	1 2 3 4 5 6 10 20 30	0 1 2 3 4 5 6 7 8 9 10 20 30 40 50 60 70 80 90

DR# PATIENT NUMBER

Date Of Birth

Social Security #

Sex: ○Male ○Female

Marital Status: ○Single ○Married ○Widowed ○Divorced ○Other

Patient Resides With: ○Lives Alone ○Spouse ○Parents ○Children ○Other

Children: ○0 ○1 ○2 ○3 ○4 ○5+

Patient's Home Address

Phone FAX

Employer Business Address

Phone

Occupation

Referred By

Spouse Name

Social Security #

A. MAJOR COMPLAINTS

1. What are your major complaints?

○None	Pain	Numbness	Tingling
Head	H	H	H
Neck	N	N	N
Upper Back	U	U	U
Mid Back	M	M	M
Lower Back	L	L	L

	R	L	R	L	R	L
Shoulder	S	S	S	S	S	S
Arm	A	A	A	A	A	A
Forearm	F	F	F	F	F	F
Hand	H	H	H	H	H	H
Buttock	B	B	B	B	B	B
Hip	H	H	H	H	H	H
Thigh	T	T	T	T	T	T
Leg	L	L	L	L	L	L
Foot	F	F	F	F	F	F

2. Currently your pain is aggravated by

○Coughing ○Lifting
○Sneezing ○Bending
○Straining At Stool ○Sitting
○Neck Movement ○Standing
○Reaching ○Walking
○Other

3. Since your symptoms began, have you noticed a change in

○Bowel Function ○Bladder Function
○Ability To Maintain An Erection

B. REVIEW OF SYSTEMS

Are you presently suffering (or within the past six months suffered) from any of the following?

1. a. GENERAL
○Normal ○Chills
○Fatigue ○Weight Change
○Weakness ○Night Sweats
○Fever ○Other

b. SKIN
○Normal ○Eczema
○Rash ○Hair Changes
○Redness ○Nail Changes
○Itching ○Other

c. NEUROLOGIC
○Normal ○Fainting
○Headache ○Convulsions
○Dizziness ○Other

d. EYES

○Normal	Right	Left
Vision Trouble	○	○
Pain	○	○
Discharge	○	○
Other	○	○

e. EARS

○Normal	Right	Left
Hearing Trouble	○	○
Ringing	○	○
Pain	○	○
Discharge	○	○
Other	○	○

f. NOSE
○Normal
○Pain ○Absence Of Smell
○Bleeding ○Other

g. MOUTH/THROAT
○Normal ○Absence Of Taste
○Sores ○Abnormal Taste
○Bleeding ○Other

h. HEART/LUNGS
○Normal ○Blue Extremities
○Cough ○Murmur
○Wheezing ○Chest Pain
○Difficulty Breathing ○Palpitations
○Swollen Extremities ○Other

i. BREASTS
○Normal ○Dimpling
○Lumps In Breast(s) ○Discharge
○Redness/Itching ○Other
○Pain

j. STOMACH/INTESTINES
○Normal ○Vomiting
○Decreased Appetite ○Diarrhea
○Increased Appetite ○Constipation
○Abdominal Pain ○Other

k. REPRODUCTIVE/URINATION
○Normal ○Impotence
○Inability To Hold Urine ○Sterility
○Painful Urination ○Other
○Frequent Urination
○Irregular Menstruation
○Painful Menstruation
○Abnormal Vaginal Bleeding

l. GLANDULAR
○Normal ○Goiter
○Heat/Cold Intolerance ○Tremor
○Sugar In Urine ○Other

m. MENTAL
○Normal ○Phobias
○Anxiety ○Mood Swings
○Depression ○Other
○Memory Loss or Impairment

907592

PLEASE MAKE NO MARKS IN THIS AREA

2. What are your habits?

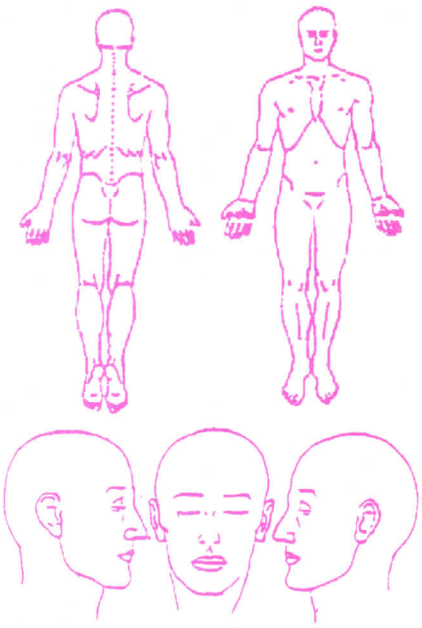
	Never	Occasionally	Moderately	Excessively
Smoking	(S)	(S)	(S)	(S)
Alcohol	(A)	(A)	(A)	(A)
Recreational Drugs	(R)	(R)	(R)	(R)
Exercise	(E)	(E)	(E)	(E)

3. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture
Father	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)
Mother	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)
Brothers	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)
Sisters	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)
Children	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)

C. PAIN DIAGRAMS

Please mark the location of your pain on these figures



D. MEDICAL HISTORY

1. HEALTH CARE

	Yes	No
a. Have you been to a chiropractor	(Y)	(N)
b. Do you have a family physician	(Y)	(N)
c. WOMEN:		
To the best of your knowledge are you pregnant	(Y)	(N)
Are you under the regular care of an OB-GYN	(Y)	(N)
d. Have you been hospitalized in the past five years	(Y)	(N)
e. Are you currently taking any medication	(Y)	(N)

- ◯ Anti-inflammatory (Aspirin, Motrin, etc.)
- ◯ Muscle Relaxants
- ◯ Pain Medication/Analgesic
- ◯ Tranquilizers
- ◯ Birth Control Pills
- ◯ Other

2. Which of the following illnesses have you had?

- ◯ *No Previous Conditions/Illnesses*
- ◯ Arthritis
- ◯ Asthma
- ◯ Sinus Trouble
- ◯ Hay Fever
- ◯ Allergies
- ◯ Tuberculosis
- ◯ Diabetes
- ◯ Epilepsy
- ◯ Thyroid Trouble
- ◯ High Blood Pressure
- ◯ Low Blood Pressure
- ◯ Heart Trouble
- ◯ HIV/ARC
- ◯ AIDS
- ◯ Sexually Transmitted Disease
- ◯ Ulcer
- ◯ Cancer
- ◯ Polio
- ◯ Rheumatic Fever
- ◯ Serious Injury
- ◯ Bone Fracture
- ◯ Dislocated Joints
- ◯ Spinal Disc Disease
- ◯ Multiple Sclerosis
- ◯ Scoliosis
- ◯ Mental/Emotional Difficulty
- ◯ Prostate Trouble
- ◯ Kidney Trouble
- ◯ Other

E. INSURANCE INFORMATION

	Yes	No
1. Is your condition due to an automobile accident	(Y)	(N)
Date of Accident		
Have You filed an accident report	(Y)	(N)
2. Is your condition due to a job injury	(Y)	(N)
Date of Injury		
Have You filed an injury report	(Y)	(N)
3. Do you have health insurance	(Y)	(N)
Company		
Policy #		
4. Are you covered by Medicare	(Y)	(N)
Medicare #		

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office 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 this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

F. PAYMENT

I WILL BE PAYING TODAY BY:

◯ Cash ◯ Check ◯ Credit Card

◯ MasterCard ◯ Visa ◯ American Express

Account # _____ Exp. Date _____

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Doctor's Signature _____ Date _____

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