

# Living with Motion Chiropractic

Keeping families young, for years to come!

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION. THANK YOU.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Acct. #: \_\_\_\_\_

How did you hear about our office?  CBYP online  Sign  Google  Yahoo  Church Bulletin  Patient

Other \_\_\_\_\_

If referred by a friend or patient, whom may we thank for their kind referral? \_\_\_\_\_

• All information is kept **STRICTLY CONFIDENTIAL**. Please complete as accurately as possible. •

• ABOUT YOU •  Check if same as Driver's License

Full Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Prefer to be called: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Marital Status:  Single  Separated  Divorced

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Married  Widowed

• MEDICAL / HEALTH CARE HISTORY •

Please list any prescriptions, over-the-counter (OTC) medications or supplements you are presently taking: \_\_\_\_\_

What health challenges are you facing creating the need for medication? \_\_\_\_\_

Please list any illnesses, accidents, surgeries and/or treatments with dates: \_\_\_\_\_

## PRIMARY INSURANCE

Policy Holder's Name: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_

Ins. Co. Name: \_\_\_\_\_ Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

• EMERGENCY CONTACT •

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever been to a chiropractor before?  No  Yes If "Yes", when? \_\_\_\_\_
2. Have you ever seen another Doctor for this problem?  No  Yes If "Yes", when? \_\_\_\_\_
3. Were you ever injured in an automobile accident either as a passenger or the driver?  No  Yes If "Yes", when? \_\_\_\_\_
4. Were you ever injured at work or as the result of employment?  No  Yes If "Yes", when? \_\_\_\_\_

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

**CHECK ANY OF THE FOLLOWING THAT PERTAIN TO YOUR MEDICAL HISTORY AND CURRENT SYMPTOMS:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Ear and Sinus Infections  | <input type="checkbox"/> TMJ/Jaw Pain            | <input type="checkbox"/> Gallbladder Issues   | <input type="checkbox"/> Constipation             |
| <input type="checkbox"/> Allergies and Congestion  | <input type="checkbox"/> Stiff Neck and Shoulder | <input type="checkbox"/> Frequent Fevers      | <input type="checkbox"/> Chron's, IBS, Colitis    |
| <input type="checkbox"/> Headaches and Migraines   | <input type="checkbox"/> Depression              | <input type="checkbox"/> Heartburn            | <input type="checkbox"/> Diarrhea                 |
| <input type="checkbox"/> Vertigo and Dizziness     | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Stomach Pains        | <input type="checkbox"/> Urination Issues         |
| <input type="checkbox"/> Vision and Hearing issues | <input type="checkbox"/> Focus & Memory Issue    | <input type="checkbox"/> Blood Sugar Issues   | <input type="checkbox"/> Endometriosis            |
| <input type="checkbox"/> Low Energy and Fatigue    | <input type="checkbox"/> Reflux/GERD             | <input type="checkbox"/> Chronic Fatigue      | <input type="checkbox"/> Infertility or Impotency |
| <input type="checkbox"/> Difficulty Sleeping       | <input type="checkbox"/> Chronic Colds           | <input type="checkbox"/> Chronic Stress       | <input type="checkbox"/> Sciatica Pain            |
| <input type="checkbox"/> Pain or Tingling in Arms  | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Allergies & Eczema   | <input type="checkbox"/> Disc Degeneration        |
| <input type="checkbox"/> Epilepsy and Seizures     | <input type="checkbox"/> Bronchitis              | <input type="checkbox"/> Kidney Problems      | <input type="checkbox"/> Leg or calf cramps       |
| <input type="checkbox"/> ADD/ADHD                  | <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Gas Pains & Bloating | <input type="checkbox"/> Gluten or Dairy Issue    |
| <input type="checkbox"/> Anxiety and Stress        | <input type="checkbox"/> Functional Heart Issues |   |   |

Please describe in your own words how you feel today: \_\_\_\_\_

Please mark your areas of pain  
On the figure below.

\_\_\_\_\_  
\_\_\_\_\_

++ Sharp/Stabbing ## Burning

XX Tingling/Numb 00 Dull

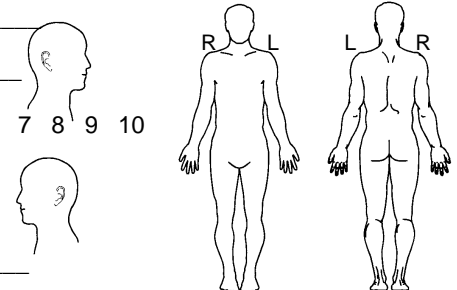
On a scale from 1-10 with 10 being the worst, circle the level of pain 1 2 3 4 5 6 7 8 9 10

Do you know why you feel this way? \_\_\_\_\_

On a scale from 1-10 with 10 being the worst, circle your overall stress level 1 2 3 4 5 6 7 8 9 10

What would you do, think, and feel if you had less pain, more energy, better sleep, and had the potential for taking less medications?

\_\_\_\_\_



Please circle the following **activities of daily living** that are affected by your current condition:

- |                    |                    |                   |                   |
|--------------------|--------------------|-------------------|-------------------|
| Bathing            | Cooking            | Laying Down       | Sleep             |
| Bending            | Daily Pet Care     | Lifting Items     | Sneezing          |
| Brushing Teeth     | Dressing           | Reading           | Sports            |
| Caring for Family  | Swallowing         | Reaching          | Static Sitting    |
| Carrying Items     | Driving            | Running           | Static Standing   |
| Changing positions | Eating             | Shaving           | Washing body/hair |
| Climbing stairs    | Exercising         | Showering         | Work activities   |
| Computer Use       | Getting out of bed | Sexual activities | Yard Work         |
| Concentration      | Household Chores   |                   |                   |

Please list any other activities that you would like to be able to do? \_\_\_\_\_

**Female Only:**

Are you currently having menstrual cycles? \_\_\_ Yes \_\_\_ No If yes, when was the first day of your last cycle?

Is there any chance you are pregnant? \_\_\_ Yes \_\_\_ No

If no, please sign here: \_\_\_\_\_

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PLEASE COMPLETE **ALL** OF THE FOLLOWING INFORMATION. THANK YOU.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Living with Motion Chiropractic is required by law to maintain the privacy and confidentiality of your protected health information.

## DISCLOSURE OF YOUR HEALTH INFORMATION

- **Treatment** - We may disclose your protected health information to doctors, hospitals, and other healthcare professionals for their provision, coordination, or management of your health care and related services.
- **Payment** - We may disclose your protected health information to insurance providers for the purpose of payment or healthcare operations.
- **Workers' Compensation** - We may disclose your protected health information to comply with State Workers' Compensation Laws.
- **Emergencies** - We may disclose your protected health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.
- **Public Health** - As required by law, we may disclose your protected health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
- **Judicial and Administrative Proceedings** - We may disclose your protected health information in the course of any administrative or judicial proceeding or in response to a legal order.
- **Law Enforcement** - We may disclose your protected health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.
- **Deceased Persons** - We may need to disclose your protected health information to coroners or medical examiners.
- **Organ Donation** - We may need to disclose your protected health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- **Research** - We may need to disclose your protected health information to researchers conducting research that has been approved by an institutional Review Board.
- **Public Safety** - It may be necessary to disclose your protected health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
- **Specialized Government Agencies** - We may disclose your protected health information for military, national security, prisoner and government benefits purposes.
- **Marketing** - We may contact you for marketing purposes or fundraising purposes. We may call you at home to confirm your appointments and may leave a message if there is no answer or you are not available. No protected health information will be disclosed other than the date and time of your next appointment. We may send a letter, postcard, invitation, or call your home in order to participate in certain events. We may from time to time send you newsletters, birthday cards, reminder cards, holiday greeting cards, thank you cards, or office letters.
- **Referrals** - We may acknowledge and express appreciation to a patient, physician, or other person who has referred you to Living with Motion Chiropractic for care. No protected health information will be disclosed other than your identity as it is known to the person referring you.
- **Change of Ownership** - In the event that Living with Motion Chiropractic is sold or merges, your protected health information / record will become the property of the new owner.

## YOUR INDIVIDUAL RIGHTS

- **Your Protected Health Information Rights** - You have the right to request restrictions on certain uses and disclosures of your protected health information. Living with Motion Chiropractic is not required to agree to the restriction. You have the right to have your protected health information received or communicated through an alternative method or sent to an alternative location. You have the right to copy and inspect your protected health information. You have the right to request the office amend your protected health information. If your request is denied you will be provided an explanation and about how you can disagree with the denial. You have the right to receive an accounting of disclosures of your protected health information. You have a right to a copy of this Notice of Privacy Practices any time upon request.
- **Changes to this Notice of Privacy Practices** - Living with Motion Chiropractic reserves the right to amend this Notice of Privacy Practices at any time and will make the new provisions effective for all information it maintains. If you have any questions about any part of this notice or if you want more information, contact Dr. Lucas Reineck at 513-831-4433.
- **Complaints** - Complaints about how Living with Motion Chiropractic has handled your health information should be directed towards Dr. Lucas Reineck at 513-831-4433. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights; 200 Independence Ave., S.W.; Room 509F; HHH Building; Washington D.C. 20201.

## ADDITIONAL INFORMATION

- **Treatment** - This office uses open room adjusting and therapy. Per request we will accommodate you to a closed room for adjusting and therapy.

This notice is effective as of Nov 1, 2008.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature I provide Living with Motion Chiropractic with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations as described in this notice. The staff of Living with Motion Chiropractic has explained the Notice of Privacy Practices to my satisfaction. I am aware that Living with Motion Chiropractic has the right to change the terms of its notice and make any provisions effective for all the protected health information that it maintains.

\_\_\_\_\_  
Patient's Name (PRINT)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date

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## Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

### Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Living with Motion Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

### Missed Appointments:

There is currently no charge for missed appointments however it's important that you adhere to your care plan to achieve the best results.

### Consent to Evaluate and Treat a Minor:

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

### Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

Others: \_\_\_\_\_

No one: \_\_\_\_\_

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [  ] No [  ]

### Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_