

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NAME OF INDIVIDUAL: _____

This is to acknowledge receipt of a copy of Lighthouse Chiropractic Health Center Inc.'s Notice of Privacy Practice with an effective date of April 14, 2003

Individual's (or Legal Representative's) Name: _____

Individual's (or Legal Representative's) Signature: _____

Date: _____

*Capacity or Authority of Legal Representative (if applicable) may be requested to provide verification of representative status.

This is to acknowledge that I authorize the following person(s) to obtain information regarding my treatment, payment, or health care operations.

Authorized Person(s)Name: _____

Patient, Parent, Guardian's Signature: _____

Date: _____

If you request any restriction(s) concerning the use of personal medical information please list below:

For Office Use Only

We made the following efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices:

However, acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify):

Authorization and Assignment

I authorize Lighthouse Chiropractic Health Center to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Lighthouse Chiropractic Health Center authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charges 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. I understand I will be charged a 1.25% month interest fee for all accounts over 30 days past due. I will also be responsible for any costs of collection, attorney's fee or court costs required to collect my bill. There will be a \$20.00 charge for returned checks. For your convenience, we accept cash, check, Visa, MasterCard, and Discover.

Informed Consent

I hereby authorize physicians and staff of Lighthouse Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Lighthouse Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness – Chiropractic adjustments and therapy modalities are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and therapy modalities. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft tissue injury.

Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Therapy Burn – Heat generated by Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above Authorization and Assignment and Informed Consent, I hereby give my consent to have chiropractic treatment administered and authorize the assignment of payments. I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient, Parent, Guardian or Personal Representative's Signature _____

Please Print Name of Patient, Parent, Guardian, or Personal Representative _____

Date _____

Relationship to Patient _____

Lighthouse Chiropractic Health Center
578 Dodge Avenue NW - Elk River, MN 55330
(763) 441-1701

Personal Information

Today's Date _____

Last Name _____ MI _____ First Name _____ Age _____

Home Address _____

City/State _____ Zip Code _____

Social Security _____ Date of Birth _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Sex: M F Martial Status: (Circle One) Minor Single Married Widowed Divorced Separated

Email Address _____

Name of Spouse/Parent _____ Date of Birth _____

Emergency Contact _____ Relationship _____ Phone _____

Who may we thank for referring you to our office? _____

Is this visit for: Personal _____ Work Comp _____ Auto Injury _____

Health Insurance Information

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

Policy # _____ Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Subscriber's Date of Birth _____ SS# _____

Relationship to Patient _____

WE NEED A COPY OF YOUR INSURANCE CARD

Lighthouse Chiropractic Health Center, Inc.

Present Complaint Form

Patient Name _____

Date _____

1. Reason for visit? _____
2. When did your symptoms appear? _____ Is this a pre-existing condition? Yes No
3. Describe how your problem began? _____
4. How did this problem begin? (Circle all that apply) Suddenly Gradually Accident Sports injury Work injury Fall
5. Please describe the character of your current pain (check all that apply) Sharp/Stabbing Sharp/Dull Aches Dull
 Weakness Throbbing/Gnawing Numbness/Tingling Shooting Gripping/Constricting Burning Tender/Sore
6. Does the pain radiate or tingle? No Yes, to Shoulder to elbow to fingers to hip to knee to toes
7. How often are the complaints present? Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)
8. Since your problem began is the pain? Increasing Decreasing Not Changing
9. What makes the problem better? Nothing Laying Down Walking Standing Sitting Movement/Exercise
10. What makes the problem worse? Nothing Laying Down Walking Standing Sitting Movement/Exercise
11. Symptoms are better at: AM Midday PM Symptoms are worse at: AM Midday PM
12. Were you previously treated for a different occurrence of this same condition?
 If yes by: Chiropractor MD Therapist Other _____ (Specify dates and type of treatment with results) _____
13. How would you grade your stress level? No Stress Minimal Stress Moderate Stress Greatly Stressed
14. Are you pregnant? Yes No Due Date _____
15. Have you ever had any surgeries or hospitalization? Yes No Please list:

Type of Hospitalization/Surgery:	Date	Type of Hospitalization/Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____

EXERCISE <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	WORK ACTIVITY <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	HABITS <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____
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MEDICATIONS _____ _____ _____ _____	ALLERGIES _____ _____ _____ _____	VITAMINS/HERBS/MINERALS _____ _____ _____ _____
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Pharmacy Name _____

Pharmacy Phone (____) _____

16. Have you been x-rayed or received MRI, CAT scan in the last 12-18 months? Yes No When? _____

17. Check those activities below during which you experience difficulty or pain:

- Lying on back Getting in/out of car Pulling Sitting Standing for long periods
 Lying on side Dressing Self Reaching Bending forward Sneezing
 Turning over in bed Sexual Activity Kneeling Bending backwards Coughing
 Lying on stomach Pushing Stooping Walking Other _____

18. Mark on the diagram where you are having the following symptoms:

Pain: XXX Numbness: OOO Aching: ////

19. Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst pain)

20. Headaches: Yes No Frequency: _____

How long have you suffered from headaches: _____

Side: Right Left Both

Location: Forehead Temple Behind Eyes Back of Head

21. What treatments have you done?

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Heat | <input type="checkbox"/> Ice |
| <input type="checkbox"/> Home Exercises | <input type="checkbox"/> Tens Unit | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Trigger Point Injections | <input type="checkbox"/> Braces | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Joint Injections | <input type="checkbox"/> Facet Injections | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Epidural Injections | <input type="checkbox"/> Pain Medications | <input type="checkbox"/> Nerve Test |
| <input type="checkbox"/> Anti-Inflammatory Medications | <input type="checkbox"/> Stretching | |

22. Review of Systems: Please check if you have recently experienced the following:

CONSTITUTIONAL

- Weight loss-last 6 months
 Fever
 Chills
 Night Sweats

GASTROINTESTINAL

- Vomiting/Nausea
 Diarrhea
 Heartburn
 Constipation
 Abdominal Pain

GENITO-URINARY

- Bladd Problems

RESPIRATORY

- Shortness of Breath
 Cough

SKIN

- Skin wounds or ulcers

FEMALE

- Bladder Problems

CARDIOVASULAR

- Chest pain
 Palpitations
 Shortness of breath w/breathing

MUSCULOSKELETAL

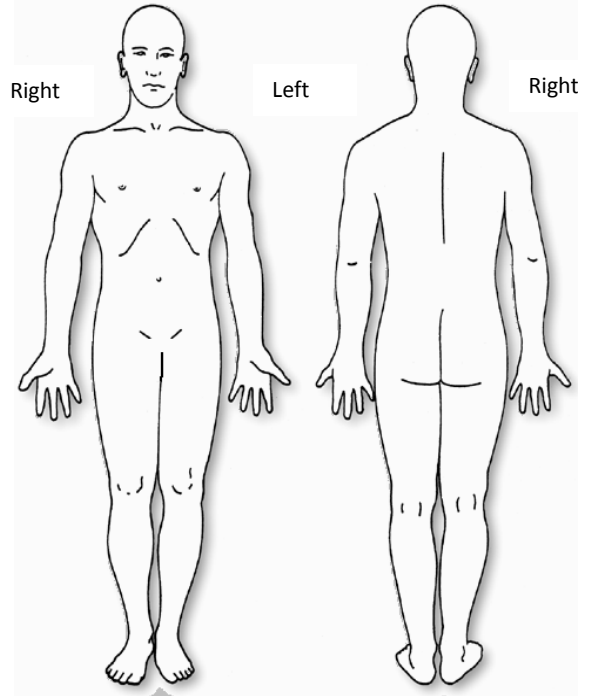
- Joint Pain
 Joint Swelling

HEMATOLOGY

- Taking blood thinning meds

NERVOUS SYSTEM

- | | | | | |
|--|-----------------------------------|---|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Numbness | <input type="checkbox"/> Muscle Jerking | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Pain going to fingers |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Ringing Ears | <input type="checkbox"/> Confusion | <input type="checkbox"/> Pain going past knee |



Present:
Weight: _____ pounds
Height: _____ ft _____ inches

Patient, Parent, Guardian or Personal Representative's Signature _____

Please Print Name of Patient, Parent, Guardian, or Personal Representative _____

Date _____

Relationship to Patient _____

LIGHTHOUSE CHIROPRACTIC HEALTH CENTER, INC.

Assessment Questionnaire

Patient Last Name	Patient First Name	Date of Birth (MM/DD/YYYY)
		____/____/____

Instructions: This questionnaire will help us understand how much your pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes your problem right now.**

SECTION 1—PAIN INTENSITY

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.
- G. Does not apply

SECTION 6—CONCENTRATION

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want.
- F. I cannot concentrate at all.
- G. Does not apply.

SECTION 2—PERSONAL CARE (Washing, Dressing, etc.)

- A. I can look after myself without causing pain.
- B. I can look after myself normally but it causes pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed; I wash with difficulty and stay in bed.
- G. Does not apply

SECTION 7—WORK

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.
- G. Does not apply.

SECTION 3—LIFTING

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.
- G. Does not apply

SECTION 8—SITTING

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than 1 hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more than 10 min.
- F. Pain prevents me from sitting at all.
- G. Does not apply.

SECTION 4—READING

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck
- E. I cannot read as much as I want because severe pain in my neck.
- F. I cannot read at all.
- G. Does not apply.

SECTION 9—STANDING

- A. I can stand as long as I want without pain.
- B. I have some pain on standing but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than 1/2 hour without increasing pain.
- E. I cannot stand for longer than 10 minutes without increasing pain.
- F. Pain prevents me from standing at all.
- G. Does not apply.

SECTION 5—HEADACHE

- A. I have no headache at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.
- G. Does not apply.

SECTION 10 - WALKING

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than 1 mile.
- C. Pain prevents me from walking more than 1/2 mile.
- D. Pain prevents me from walking more than 1/4 mile.
- E. I can only walk using a stick or crutches.
- F. I am in bed most of the time and have to crawl to the toilet
- G. Does not apply.

Assessment Questionnaire

Continued

SECTION 11—DRIVING

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my car at all because of severe pain in my neck.
- F. I cannot drive my car at all.
- G. Does not apply

SECTION 12—TRAVELING

- A. I get no pain while traveling.
- B. I get some pain while traveling but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain restricts all forms of travel except that done lying down.
- G. Does not apply

SECTION 13 – RECREATION

- A. I am able to engage in all recreational activities with no pain in my neck at all.
- B. I am able to engage in all recreational activities with some pain in my neck.
- C. I am able to engage in most, but not all recreational activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.
- G. Does not apply

SECTION 14— SOCIAL LIFE

- A. My social life is normal and gives me no pain.
- B. My social life is normal but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, (e.g. dancing, etc.).
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.
- G. Does not apply.

SECTION 15 - SLEEPING

- A. I have trouble sleeping.
- B. My sleep is slightly disturbed (Less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).
- G. Does not apply.

SECTION 16 – CHANGING DEGREE OF PAIN

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.
- G. Does not apply.

I understand that the information I have provided above is current and correct to the best of my knowledge.

SIGNATURE _____ DATE _____