Update Patient Information Chiropractic / Naturopathic
We are in the process of updating our records to comply with federal standards.
Please answer the following questions:

Name: _____ **Date:** _____

Referred By: _____

_____Left Handed _____ Right Handed ____Ambidextrous

Preferred Language?
_____ English _____Spanish

Race?
_____ I do not wish to provide this information
_____ White
_____ Black or African American
_____ Native American or Alaska Native
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ Other

Ethnicity?
_____ I do not wish to provide this information
_____ Hispanic or Latino
_____ Non-Hispanic or Non-Latino
_____ Other

Smoking Status?
_____ Current Every Day Smoker
_____ Current Some Day Smoker
_____ Former Smoker
_____ Never Smoker

Do you have any Allergies including medications?
_____ No known medciation allergies

_____ Yes. What? _____

Are you currently taking any medications?
_____ Not currently prescribed any medications

_____ Yes. What? _____
What?_____ Taken For: _____
What?_____ Taken For: _____
What?_____ Taken For: _____

BOLD FOR STAFF USE ONLY:

Temperature: _____

Oxygen Saturation: _____

Pulse Rate: _____

Raglands Test:
BP Lying: _____

BP Standing: _____

BMI: _____

Zinc Test:
_____ **No Taste**

_____ **Some Taste**

_____ **Metallic Taste**

Further Testing:
_____ **Recommended**

_____ **Not Recommended**

Body Weight: _____

Body Fat: _____

(Revised 6/9/22 - vmc)

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Other _____		
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No						
			Measles	☐ Yes	☐ No						

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

Allergies

_____
_____
_____
_____
_____

Vitamins/Herbs/Minerals

_____
_____
_____
_____
_____

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to my insurance carrier for payment if needed. I authorize any holder of medical or other information about me to release to me upon request and or an insurance carrier or any agency or Health Care Financing Administration and its agents or the Social Security Administration or any agency, group, or person (s) for and in consideration of services rendered and to be rendered by the above and understand payment policy of the Loechinger Chiropractic Clinic. If this account goes to collection, I agree to pay all collection and attorney fees.

Our office policy for late cancellations and or no shows:

- **We ask that you give us at least 24 hours notice to avoid a possible charge.**
- **If you no-show for your scheduled appointment, you may be subject to a fee being charged to your account.**
- **After three no-shows you will be dismissed from the practice**

Our return policy for unopened Supplements and Homeopathic Medicine is 30 days from purchase. Opened supplements and homeopathic drops cannot be returned.

PRINT NAME: _____

SIGNATURE: _____

DATE:_____

HEART SOUND RECORDER SURVEY FORM

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

If a symptom does not apply, do not circle anything for that symptom.

Name:_____

Date:_____

Age: _____ DOB: _____ M / F

Height_____ Weight: _____

1.	1	2	3	Ringing in ears
2.	1	2	3	Dizziness
3.	1	2	3	Tired throughout day
4.	1	2	3	Swollen ankles
5.	1	2	3	Poor circulation
6.	1	2	3	Breathing challenges
7.	1	2	3	Afternoon "yawner"
8.	1	2	3	Difficulty catching breath, especially during exercise
9.	1	2	3	Aware of "breathing heavily"
10.	1	2	3	Tightness or pressure in chest, worse on exertion
11.	1	2	3	Fatigue upon exertion
12.	1	2	3	Hands and feet go to sleep easily, numbness
13.	1	2	3	Muscle weakness
14.	1	2	3	Muscle cramps, worse during exercise, get "charley horse"
15.	1	2	3	Muscle spasms
16.	1	2	3	Heart pounds at night
17.	1	2	3	Heart races after alcohol consumption
18.	1	2	3	Heart races
19.	1	2	3	Heart flutters
20.	1	2	3	Sensitive to cold

Yes No Daily bowel movement

Are you taking any of the following medications?

Yes No Cholesterol If yes, name of medication:_____

Yes No Blood pressure If yes, name of medication:_____

Yes No Blood sugar If yes, name of medication:_____

Yes No Other If yes, name of medication:_____

_____

Yes No **Are you taking any additional supplements?** If yes, names of supplements:_____

_____

_____

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

___/___	Blood Pressure	_____	Hydrochloric Acid Point
_____	Enzyme Point	_____	Murphy's Sign (Gallbladder)
_____	Heart Rate	_____	pH of Saliva
_____	Holding Breath Test (20 sec minimum)	_____	SpO_2%

Cuff Test: Pass / Fail Cuff Pressure: _____ Pupil Dilation Exam: Pass / Fail

LOECHINGER CHIROPRACTIC CLINIC
180-A East Spring Valley Road
Dayton, Ohio 45458

937-434-8700

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Loechinger Chiropractic Clinic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office, which will be given to you at your initial visit.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

You will have the opportunity to talk to your Doctor and Staff members in private. However, this practice provides treatment in open areas. If you have comments you wish to make privately please inform the Doctor or Staff and we will accommodate your request.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date