

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

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

Are you pregnant? Yes No Due Date _____

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

Medications

Allergies

Vitamins/Herbs/Minerals

Pharmacy Name _____ Pharmacy Phone (____) _____		
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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 or Medicare 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 is for Supplements and Homeopaths is 60 days from purchase.

NAME: _____

DATE: _____

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:** _____

_____ 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 medication 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: _____

Zinc Test:

_____ **No Taste**

_____ **Some Taste**

_____ **Metallic Taste**

Further Testing:

_____ **Recommended**

_____ **Not Recommended**

For KETO Diet:

Body Weight: _____

Body Fat: _____

BMI: _____

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.

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

RESTRICTIONS ON USE The Heart Sound Recorder Survey is to be used only by trained health care professionals. If you are a patient, you should not use the Heart Sound Recorder Survey. If you are not a trained health care practitioner, you should not use the Heart Sound Recorder Survey. Health care practitioners should only use the Heart Sound Recorder Survey to provide services that are within the scope of their license or professional training. The Heart Sound Recorder Survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.

Name: _____

Date: _____

Age: _____ DOB: _____ M / F

Height: _____ Weight: _____

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