Lotus of Life Chiropractic

info@lotusoflifechiropractic.com

New Patient History and Health Concerns

**Please do your best to fill out everything on this intake form. It is important that I understand past and current stressors that may have affected or could affect your child's health. It is important for me to know the following information, even if it may not seem relevant to the reason for which you are coming in for care. Please know that I value your time and aim to provide you the best care possible. Thank you for choosing Lotus of Life Chiropractic and Wellness Center!*

Check type of care desired: __Temporary Relief / __Stabilization / __Family Health/ Prevention/ __Doctor's Advice

Name: _____ DOB: _____ Age: _____ Gender: M/F/____

Address:_____ City:_____ State:_____ Zip Code: _____

Home Phone: _____ Email: _____

Partner/Spouse's Name: _____ Cell: _____

Childrens' Names and Ages: _____

Who referred you to our office? _____ May we thank them? Yes No

Is this related to an auto accident or injury involving a third party? Yes No (If yes, please speak with the front desk.)

About Your Health

The human body is designed to be healthy. Throughout life events occur and our body has two options: It can either integrate experiences or store them to be integrated at a later time when the body is better capable. These stored experiences eventually become symptoms in the body, thus giving us a lesser quality of life. This case history will uncover the layers of stored experiences in your body. Following the exam, you will get an outline of care that will begin to correct and release these layers and recover your innate health potential!

Your Healthcare Team (include all doctors, therapists, trainers, specialists, etc)

Provider's Name	Provider Type	Last Visit	Reason	Result

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Current Health Concerns (Please follow instructions carefully. We will cover all health concerns verbally.)

List your top three health concerns? _____

Which is most important to you and why? _____

When/how did this concern first begin? _____

What activities aggravate your concern? _____

What activities alleviate your concern? _____

Is the condition worse during certain times of the day? Y N If yes, when? _____

Does it affect your ___work ___relationships or intimacy ___decision making ___exercise or play

___attitude, mood, patience ___ability to relax or sleep ___ day-to-day activities

Health History

Mark any system or issue you have with ***(N) for Now or (P) for Past*** *(Including Birth until Now)*

___ Nervous System	___Prostate	___ Arthritis	___ Accidents/Falls/Injuries/Concussions
___ Musculoskeletal	___ Eyes	___ Sinuses/Allergies	___ Surgeries/Organ Removal
___ Digestive	___ Ears/Nose/Throat	___ Seizures	___ Fractures/Dislocations
___ Respiratory	___ Dental/Jaw issues	___Cancer	___ Cholesterol/Blood Pressure
___ Cardiovascular	___ Thyroid	___Stroke	___ Vaccine Medication Reaction
___ Immune	___ Adrenals	___ Scoliosis	___ Depression/Anxiety
___ Reproductive	___ Learning Difficulties	___ Anemia	___ Diabetes (Type:_____)
___ Bowels/Bladder	___ Headaches/Migraines	___ Dizziness/Vertigo	___ Significant Family History
___ Skin	___ Numbness/Tingling	___ Autism Spectrum Disorder	___Other

Mom's Pregnancy (check all that apply) If adopted and no details are known please check here _____

Any complications, illnesses, medications, abuse, or injury during your birth?_____

Were you born vaginally or by C-section?_____ Were you breastfed? Yes No

Any illnesses, surgeries, medications, injuries, or mental illness during your childhood, ages 0-18? (Ie. – asthma, ear infection, allergies, eczema, etc.)_____

_____

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Childhood (Age 0-18): (check all that apply)

Developmental History:

Breast Fed: Yes No How Long? _____ **Formula Fed:** _____Dairy _____ Soy How Long? _____

Breastfeeding issues / Reason formula fed?_____

Age when **solids** were introduced: _____ **Food Allergies** Yes No _____

Food Sensitivities _____

Vaccine History: ___Full CDC schedule ___ Selective schedule ___ Delayed, Full schedule ___ None

Why? _____

Medications (type and reason): _____

Supplement (type, reason and who recommended): _____

_____

Chiropractic and Nutrition Response Testing History

Have you ever had **Chiropractic Care**? Y N Doctor or Office's Name: _____

Last visit: _____ Duration of care: _____

Reason for visit: _____ Result: _____

Have you ever had **Nutrition Response Testing**? Y N Doctor or Office's Name: _____

Reason for visit: _____ Result: _____

Household Habits

Do you **filter** your drinking/cooking/shower water? Yes No _____

Do you eat **organic foods**? Yes No _____

Do you use **organic health products** (soaps, shampoos, detergents)? Yes No _____

Do you **filter your air** at home? Yes No _____

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Nutrition / Toxins: mark yes or no in regards to consumption. If yes, write details in space provided.

Drugs: *Prescription* Yes No Type and reason _____

Over the counter Yes No Type and reason_____

Recreational Yes No Type_____

Supplements: *Prescription* Yes No Type and reason _____

Over the counter Yes No Type and reason_____

Caffeine: Yes No Source/frequency/amount:_____

Tobacco: Yes No Source/frequency/amount: _____

Alcohol: Yes No Type/frequency/amount: _____

Water: Yes No Type/amount: _____

What did you eat yesterday?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____**Drinks:**_____

Do you avoid any foods due to allergies, sensitivities, or religion? Yes No _____

Other Providers and Doctors (Office and provider name, last visit) _____

_____

Occupation: _____ How long have you been at this job?_____

Do you enjoy what you do? Yes No Is your job physically and/or mentally stressful? Yes No

_____

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Life Health

What do you do for **exercise** (type, frequency, duration)? _____

What do you wish you were doing in the way of activity/exercise that you are currently not participating in?

_____

Do you consider yourself **spiritual and/or religious**? Yes No If yes, do you **pray** or **meditate** regularly? Yes No

Do you work with a **life coach**? Yes No

Name: _____How long? _____

Are you under care of a **psychologist and/or psychiatrist**? Yes No

Name: _____How long? _____

Do you have a history of physical, emotional, verbal, sexual **abuse**, or rape? Yes No

Have you or are you currently addressing that topic with a professional? Yes No

If yes, who: _____ If no, would you like a referral? Yes No

Is there some aspect of your life that very much **pleases** you, brings you joy, or helps you to feel better about yourself?

_____

Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel **impair** your opportunity for full, unimpeded health?

_____

Are there any particular factors or elements about your life, experiences, family, work, recreation, genetics, dietary programs, exercises, outlook, etc. that you feel give you an edge or **adds to your health**?

_____

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Stress Survey:

0 - no awareness of any stress **1**- slightly stressful **2**- moderately stressful **3**- extremely stressful

Please circle a number and the examples that apply to you. If not listed, please write in.

Overall Physical Stress/Trauma:

0 1 2 3

Includes: falls, accident, injuries, repeated postural stress, impacts, difficult birth, physical/sexual abuse, etc.
Other: _____

Overall Emotional/ Mental Stress:

0 1 2 3

Includes: loss/separation of loved ones, life changes, abuse, legal concerns, financial concerns, relocation, illness of yourself or loved one, job stress, etc.
Other:_____

Overall Chemical Stress:

0 1 2 3

Includes: drugs, medicines, alcohol, nicotine, caffeine, smoke, fumes, chemical agents, pollution, food additives, poor diet (fast food, fried food), pesticides, non-organic food/body products, etc.
Other: _____

Is there anything else which may help us to understand you, your history, or your needs which have not been discussed on this survey? Please explain: _____

Participant Signature: _____ Date: _____

**** Remember, health is a process. Past and present choices affect this process. Thank you for taking the time to provide us with the information we need to best help you achieve your health goals. Congratulations on taking an active step toward health and thank you for giving us the opportunity to participate in that process!***

Practitioner Name: _____

Practitioner Signature: _____ Date: _____

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History on Past and Current Pregnancies and Births

Are you **currently pregnant**? Yes No

How many weeks are you? _________________ Guess Date: ____________________

Do you plan on birthing at: ___Home ___Birthing Center ___ Hospital
If not birthing at home, please name birthing location: _____________________________________

Do you plan on using a: (check all that apply) ___Doula ___Midwife ___Nurse Midwife ___OB
Names: ____

Do you plan on breastfeeding? (Please answer assuming there are no unexpected issues.)

Yes: For how long and why? ____

No: why not? ______________________________

Do you plan on vaccinating this child? Yes No

If yes, what type of schedule are you choosing: ___CDC Full ___Delayed Full ___Modified

Why? ____

Have you done your own research on vaccinations? ____

~~~~~~

Have you ever had an abortion? Yes No Age(s): ___________ Complications:______________________________

Have you ever had a miscarriage? Yes No Age(s): ___________ Complications:______________________________

~~~~~~

Past Deliveries: How many? ______ Complications? _____________________________ C-Section? _______________

Notes: ____

____

Participant Signature: _____________________________ Print: ____________________________ Date:____________

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HEALTHCARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Healthcare Information (PHI). The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the chiropractic office.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Lotus of Life Chiropractic to use and/or disclose PHI in accordance with the following:

SPECIFIC AUTHORIZATIONS: _____ I give permission to Lotus of Life Chiropractic to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, other practice related correspondence, information about treatment alternatives or other health related information.

_____ If Lotus of Life Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

_____ I give permission to Lotus of Life Chiropractic to use my name on a welcome board, referral board, and birthday board.

_____ I give permission to Lotus of Life Chiropractic to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

_____ I give permission to Lotus of Life Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

_____ I give Lotus of Life Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Lotus of Life Chiropractic permission to use and disclose your PHI in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Lotus of Life Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION: You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Lotus of Life Chiropractic. The written notice must contain the following information: Your name and date of birth; A clear statement of your intent to revoke this AUTHORIZATION; The date of your request; and Your signature.

The revocation is not effective until it has been received by the Privacy Official.

This AUTHORIZATION is requested by Lotus of Life Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Lotus of Life Chiropractic will not refuse to provide treatment however, it will not be possible for Lotus of Life Chiropractic to contact me to schedule appointments or discuss my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, within boundaries, the PHI to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed AUTHORIZATION will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practice for Protected Health Information. My signature below represents agreement with these practices.

DOB:_____

Participant's Name (please print):_____

Participant's Signature:_____

Today's Date:_____

Name of Personal Representative (if someone is designated to act on your behalf/or for minor)

Parent or Personal Representative's name (please print):_____

Signature:_____

Today's Date:_____