



LAKESHORE FAMILY CHIROPRACTIC, PLC

Dr. Blake R. Spooner & Dr. Samantha Spooner
244 W. James St., Holland, MI 49424 (P) 616.396.6635 (F) 616.396.6679

Name _____ Gender _____ Date _____
 Date of birth _____ Age _____ Social Security number _____
 Address _____ City _____ State _____ Zip _____
 Phone # _____ Cell # _____ Work # _____
 Email _____ Marital Status _____ Ages of children _____
 Employer _____ Occupation _____
 Spouses name _____ Spouses Occupation _____

PRIMARY REASON FOR CONSULTING OFFICE

Present complaint _____
 Pain or problem started on _____ Frequency: Daily 2-3 times weekly Sporadic
 Pains are: Sharp Dull Constant Intermittent
 On a scale of 0 to 10, how would you rate your pain/symptoms today? (Please circle a number below)
 None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible
 Is this condition worse at certain times of the day? Morning Afternoon Evening During sleep
 Is this condition getting progressively worse? Yes No
 Is this condition interfering with: Work Sleep Routine Other _____
 Have you been under medical care recently or for this problem? Yes No
 Have you been taking prescriptive or non-prescriptive drugs? Yes No Type: _____
 Have you had surgery? Yes No Explain _____
 Any side effects from drugs or surgery? Yes No Explain _____
 Are you using any home remedies? Yes No Explain _____
 When did you last see a chiropractor? _____ Dr/Office name: _____
 Why did you see this chiropractor? _____ Were you helped? Yes No
 What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

 Did you follow it? Yes No If not, why _____
 Why are you changing chiropractors? _____

HEALTH HISTORY

<p><i>Now Have In the Past Family History</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fractured bones <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Auto accidents ___ 0-5 years ___ over 5 years <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other accidents or falls <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knocked unconscious <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Back curvature <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen or painful joints <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent colds/flu <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tension/Stress <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Depression <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergies <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Light headed upon rising <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ringing in ears <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hearing Loss 	<p><i>Now Have In the Past Family History</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of balance <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blurred vision <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Trouble sleeping ___ Stomach sleeper ___ Side sleeper ___ Back sleeper <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Learning disability <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headaches <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck Pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck stiffness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness/tingling ___ Hand/Fingers ___ Arms ___ Legs ___ Feet/Toes ___ Buttocks ___ Head or face <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Head seems heavy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty Standing 	<p><i>Now Have In the Past Family History</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty Driving <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulder pain/stiffness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hip pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Upper back pain/stiffness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mid back pain/stiffness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain/stiffness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain when coughing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other organ problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menstrual problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed wetting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DS/HIV
---	---	--

Office Use Only: Doctor has reviewed this information with the patient. _____ Date: _____



LAKESHORE FAMILY CHIROPRACTIC, PLC

Dr. Blake R. Spooner & Dr. Samantha Spooner
244 W. James St., Holland, MI 49424 (P) 616.396.6635 (F) 616.396.6679

Name _____ Gender _____ Date _____
Date of birth _____ Age _____ Social Security number _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEMS

- Temporary Relief (Help the symptom but do not fix the cause of the problem)
- Maximum Correction (Correct the cause of the problem so it does not return)

WHY DID YOU COME TO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US? _____

What are your favorite activities or hobbies to do now? _____

Are your problems affecting your ability to either perform or enjoy these activities? Yes No

What activities are you looking forward to doing as you get older? _____

Do you believe if your problems go uncorrected and get worse you will be able to enjoy these activities?
 Yes No

On a scale of 1-10 (10 being the most, and 1 being the least)

- _____ How committed are you at being at your maximum health potential?
- _____ How important is it for your family to be at their maximum health potential?
- _____ How committed are you to preventing arthritis in your spine?
- _____ How committed are you to fixing your current and future health problems?

When is the last time you had your entire families spines checked? _____

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understands both the objective and the method that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **Vertebral Subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and understand the above statements and therefore accept chiropractic care on this basis.

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Print Name Signature Date



LAKESHORE FAMILY CHIROPRACTIC, PLC

Dr. Blake R. Spooner & Dr. Samantha Spooner
244 W. James St., Holland, MI 49424 (P) 616.396.6635 (F) 616.396.6679

Name _____ Gender _____ Date _____
Date of birth _____ Age _____ Social Security number _____

INSURANCE ASSIGNMENT PROGRAM

The following insurance assignment program allows you to receive the care you need without undue financial strain. Waiting for insurance payment is a *courtesy* provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and a supportive health care program is recommended. We will notify you of the change.

All deductible amounts must be paid by you in advance of the first billing. Also, you must stay current with your percentage of responsibility. This must be paid at least weekly. Pre-payments may also be made. The insurance carriers are billed weekly. It is your responsibility to supply this office with the necessary forms to complete billing if needed.

If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the clinic. Failure to do this may result in collection action.

If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.

This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his/her own. The insurance company has 30 days from billing date to make this decision. Patient payment is expected on any fees over 30 days old.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by provisions as specified above.

Patient Signature _____ Date _____

PAYMENT POLICY and FEE SCHEDULE

In our best efforts for clear communication at Lakeshore Family Chiropractic, please read the fee structure and sign below to acknowledge. Lakeshore Family Chiropractic accepts the following forms of payment:

- CASH / CHECK / CREDIT & DEBIT CARDS** - Every time you come in.
After 60 days of non-payment, a \$25.00 late fee will be added to your account to be compounded monthly. Checks will also be subjected to a \$25.00 administrative fee.
- INSURANCE ASSIGNMENT**- Co-pay, insurance reimbursement signed over to our clinic.

<u>Services</u>	<u>Normal Fees</u>	<u>Services</u>	<u>Normal Fees</u>
Consultation	No charge	X-Rays	\$55 -\$200
Exams	\$30 - \$60	Computer Scans	\$30
Adjustment	\$45 - \$60	Massage	\$60/hour
Mechanical Traction	\$20		\$ 30/half hour

Mechanical traction is a type of Physical Therapy and is NOT part of a chiropractic adjustment. Additional charges may apply for this service.

Patient Signature _____ Date _____



LAKESHORE FAMILY CHIROPRACTIC, PLC

Dr. Blake R. Spooner & Dr. Samantha Spooner
244 W. James St., Holland, MI 49424 (P) 616.396.6635 (F) 616.396.6679

Name _____ Gender _____ Date _____
Date of birth _____ Age _____ Social Security number _____

HIPPA PRIVACY PRACTICES

I acknowledge that **Lakeshore Family Chiropractic, PLC** "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Lakeshore Family Chiropractic's Notice of Private Practices prior to signing this document. Lakeshore Family Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations at Lakeshore Family Chiropractic, PLC. The Notice of Privacy Practice is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Lakeshore Family Chiropractic, PLC's duties with respect to my protected health information.

Lakeshore Family Chiropractic, PLC, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (Parent, legal guardian, etc.)

Please list below the names of person(s) authorized to gain access to patient account information:

