Lakeway Wellness, PLLC

PATIENT HEALTH HISTORY FORM

Date:_____

Name _____ How did you hear about us?_____

Date of Birth _____/_____/_____ Age_____ Gender: M F Other

Address _____City_____ State _____Zip_____

Marital Status _____ Spouse's Name _____# Children_____

Home or Cell Phone (_____) _____Email _____

Occupation_____Employer _____Work Phone_____

Parent's Names (if you are under 18) _____

My goal for consulting with the doctor: □ Temporary Relief □ Lasting Correction □Let doctor recommend best type of care

Describe your major complaint:

Timing: 0-25% 26-50% 51-75% 76-100%

When did your symptoms begin?_____ Have you had similar symptoms in the past? □Yes □No

How did your symptoms begin? □ Work Injury □ Auto Accident □ Other (describe):_____

*If from a personal injury or auto accident, please fill out Personal Injury Questionnaire

Progression (circle): Improving Not-Improving Worsening What makes it worse?_____

Describe: Sharp Shooting Achy Burning Numb Tingling What makes it better?_____

How severe are the symptoms on a scale of 1-10?(circle) NONE -1 2 3 4 5 6 7 8 9 10-WORST

In general, how would you rate your current overall health? Excellent Very Good Good Fair Poor

Has it affected your ability to work or do housework? □Yes □No How many days off from work/housework?_____

What activity would you like to be able to do again that is difficult or that you cannot do now?_____

What are your favorite hobbies or activities?_____Currently Affected? □Yes □No

Have you seen a Chiropractor in the Past? □Yes □No if yes, when was your most recent visit?_____

Why did you see the Chiropractor?_____Doctor's Name?_____

What frequency was prescribed for your care?_____

When was your most recent set of spinal x-rays?_____

Have you had any MRI's or CT scans? Y N If yes, when and where?_____

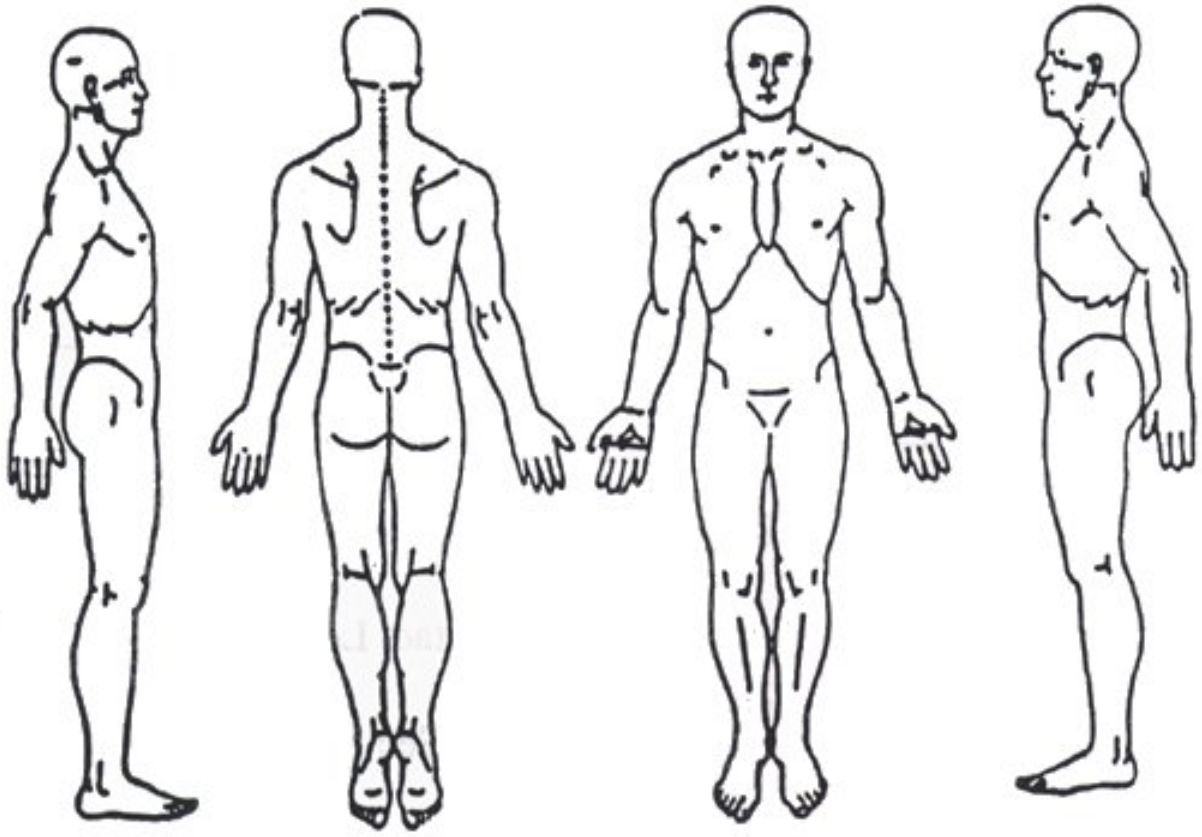
Are you currently using/wearing foot orthotics? If so, are they custom made and fit to your feet? Y N

Who is your Primary Medical Physician? _____Clinic name/Phone_____

When was your last set of medical blood or urine tests?_____

PLEASE MARK AND DESCRIBE ANY PAIN OR DISCOMFORT ON THE DIAGRAM BELOW.

If there was an accident or trauma, please describe:



HEALTH HISTORY - Please read through the list and check the box next to each condition that applies to you.

Last known: Height_____ Weight_____ Blood Pressure _____/_____(don't know)
Do you have an exercise routine? If so, please explain_____
Are you pregnant? □Yes □No
How is your diet?_____

Musculoskeletal - General
Now Past
□ □ Degenerative arthritis
□ □ Rheumatoid arthritis or Gout
□ □ Compression fracture
□ □ Osteomyelitis
□ □ Osteoporosis

Musculoskeletal Spine
Now Past
□ □ Poor Posture
□ □ Disc injury
□ □ Neck problem
□ □ Mid-back problem
□ □ Low back problem
□ □ Scoliosis
□ □ Ankylosing spondylitis
□ □ Difficulty swallowing because of neck pain
□ □ Pain or electric shocks in arms or legs on moving neck

Musculoskeletal Extremity
Now Past
□ □ Hip or sacroiliac problem L R
□ □ Leg, Knee, ankle or foot L R problem
□ □ Shoulder problem L R
□ □ Arm,elbow,hand problem L R
□ □ Rib or chest pain

Nervous System
Now Past
□ □ Headaches or migraines
□ □ Tingling or numbness of arms, legs, hands or feet
□ □ Pinched nerve or sciatica
□ □ Poor balance
□ □ Depression or Anxiety
□ □ Difficulty dealing with stress
□ □ Dizziness or vertigo
□ □ Learning disorder or hyperactivity (ADD/ADHD)
□ □ Seizures/Epilepsy
□ □ Recent progressive muscle weakness or shaking
□ □ Numbness of inner thighs/groin

EENT
Now Past
□ □ Jaw, TMJ or mouth problem
□ □ Visual problems
□ □ Ear problems, infections or ringing
□ □ Chronic sinus problems
□ □ Face pain

GI/GU/Endocrine
Now Past
□ □ Abdominal pain
□ □ Constipation/Diarrhea
□ □ Heartburn/Acid Reflux/Ulcers
□ □ Uncontrolled Bladder or Bowel
□ □ Inflammatory bowel disease
□ □ Liver or gallbladder problems
□ □ Menstrual problems or PMS
□ □ Menopause symptoms
□ □ Difficulty getting/staying pregnant/other

Cardio-Pulmonary
Now Past
□ □ Pacemaker or implanted device
□ □ Breathing trouble or Asthma
□ □ High blood pressure
□ □ History of stroke or aneurysm

Medication-Related Issues
Now Past
□ □ Medication dependence
□ □ Drug or Vaccination reaction
□ □ Current drug side-effects
□ □ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
□ □ 3 or more months of steroid medications or intravenous drugs (past or present)

Injuries and General
Now Past
□ □ Car crash/whiplash injuries
□ □ Work injuries
□ □ Ergonomic stress at work
□ □ Sports injuries
□ □ Smoking habit: How much/day?_____
□ □ Drug or alcohol dependence or recovering
□ □ Psoriasis or psoriatic arthritis
□ □ Unexplained weight loss
□ □ Sleeping trouble
□ □ Get sick a lot/poor immune function
□ □ Fibromyalgia / Chronic fatigue
□ □ Tuberculosis, Hepatitis or HIV
□ □ Cancer or Tumor
□ □ Allergies:_____
□ □ Recent fever over 102°F
□ □ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
□ □ Constant pain that doesn't improve by changing positions or by lying down
□ □ OTHER HEALTH PROBLEM NOT LISTED:_____
_____
_____

FAMILY HISTORY:
(circle any that apply)
Back problems - Back/neck surgery - Heart problems – Diabetes - Rheumatoid arthritis - High Blood Pressure - Cancer
Other:_____
_____

LIST ALL SURGERIES AND PROCEDURES YOU HAVE HAD:
_____
_____
_____
_____

LIST ALL MEDICATIONS/VITAMINS/ SUPPLEMENTS/HERBALS:
_____
_____
_____

LIST ANY TRAUMA'S, DATE, AND DESCRIPTION:
_____
_____
_____

CONSENT TO INITIATE CARE

Welcome to our office. In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this practice:

A. Chiropractic is a licensed health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery.

B. The Practice of Chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health.

C. Chiropractic evaluation and examination is part of the standard chiropractic procedure. It is designed to identify health problems and chiropractic needs. Doctors of Chiropractic focus particular attention on prevention and correction of Subluxation.

D. Subluxation (particularly of the spine) is a complex of alignment, movement and/or pathological joint abnormalities that chokes off or compromises nerve integrity causing abnormal organ system function and ill health.

E. Chiropractic Adjustment is a very specific manipulation, only performed by licensed chiropractors, to eliminate Subluxation and allow normal nerve function and health restoration. Chiropractic Adjustments are safe, effective procedures applied over one-million times each day in the United States alone.

F. Prevention of Subluxation is accomplished through maintenance adjustments and nutritional, mental, and physical wellness habits taught and prescribed by Doctors of Chiropractic. Based on your condition, this office may also utilize adjunct therapeutic procedures as well.

G. We invite you to speak frankly to the doctor or staff on any matter related to your care at our office. We work to maintain as a supporting, open environment.

H. We do not seek to replace or compete with medical, dental or other type(s) of health professionals and will provide referral for other evaluation if the doctor feels it is the best interest of his patient. Those providers retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by other providers.

I. Your compliance with Chiropractic Adjustment schedules and instructions is essential to maximum healing and optimal health through Chiropractic. We will work diligently to help you meet your Chiropractic needs.

J. Cancellation Policy: Your time is invaluable, as is Dr. Padrta. Your appointment time is reserved for you and we do our best to give you the care you deserve and need with minimal to no wait. Please give adequate notice for cancelled or rescheduled appointments or a fee may apply.

We are committed to providing the highest quality care possible so that you and your family may enjoy an active, healthy life, with affordable fees. Thank you for taking the first step towards restoring and maintaining your spinal health.

I understand all of the above information and give consent for chiropractic and nutritional evaluations and care to be performed by Dr. Padrta.

Patient or Guardian's Signature_____ Date _____

Print Name_____

HIPPA Procedures and Authorization

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our office at 865-582-1504.

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information given to me and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ Date:_____

OFFICE APPOINTMENT POLICY FORM

Every patient in our practice receives a personal reservation, dedicated just to you.

***Please reschedule your appointment at least 24 hours before your reserved appointment*.**

You will receive a courtesy text or e-mail as a reminder.

I understand that repeated cancellations or missed appointments will result in loss of future appointment privileges, as well as removed from the schedule for any remaining appointments for the year. Missed appointment fee is $60.

Our office does not accept insurance, nor bill or give out claim forms/receipts for insurance reimbursement. Our main focus is caring for patients, rather than charging extra to cover the cost of dealing with insurance paperwork. If you would like a referral who bills insurance, we will be glad to give you one.

I UNDERSTAND THAT DR. PADRTA DOES NOT ACCEPT INSURANCE AND WILL NOT SUBMIT OR GIVE FORMS FOR INSURANCE SUBMISSION/REIMBURSEMENT.

Patient Signature: _____