RICHMOND
Chiropractic Center
Ryan Lauck, DC, FMT

Personal Information

Today's Date: _____

Patient Name: _____ _____ _____ _____
(Last) (First) (M.I.) (Nickname)

Birthdate: _____/_____/_____ Age: _____ SS#:_____-_____-_____ ☐ Male ☐ Female

Address: _____City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Occupation: _____ Email Address: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name _____ Emergency Contact: _____ Contact Number: _____

Who may we thank for your referral? _____ PCP: _____

Have you been to a chiropractor in the past? ☐ Yes ☐ No Name: _____

Health History

Date of last:

Physical Exam _____ X-Ray _____ MRI _____ CT or Bone Scan _____

Are you taking any of the following medications? ☐ Insulin ☐ Pain Killers (including OTC medication)

☐ Muscle Relaxers ☐ Blood Thinners ☐ Tranquilizers ☐ Nerve Pills ☐ Other(s) _____

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

AIDS/HIV	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Prostate Issues	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herniated Disc	☐ Yes ☐ No	Sinus Condition	☐ Yes ☐ No
Backaches	☐ Yes ☐ No	Other Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Thyroid Issues	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Digestive Disorders	☐ Yes ☐ No	Neuritis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Dizziness/Vertigo	☐ Yes ☐ No	Numbness	☐ Yes ☐ No	Other	
Emphysema	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	_____	
Epilepsy	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	_____	
Fractures	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	_____	

Exercise
☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

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

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Please describe any injuries or surgeries you have had: _____

_____

_____

Your Concerns

What is your major complaint or concern? _____

_____

When did your symptoms appear? _____

Are your symptoms: ☐ Getting worse ☐ Getting better ☐ Staying the same

What treatment(s) have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other _____

Other doctor(s) that treated you for this condition: _____

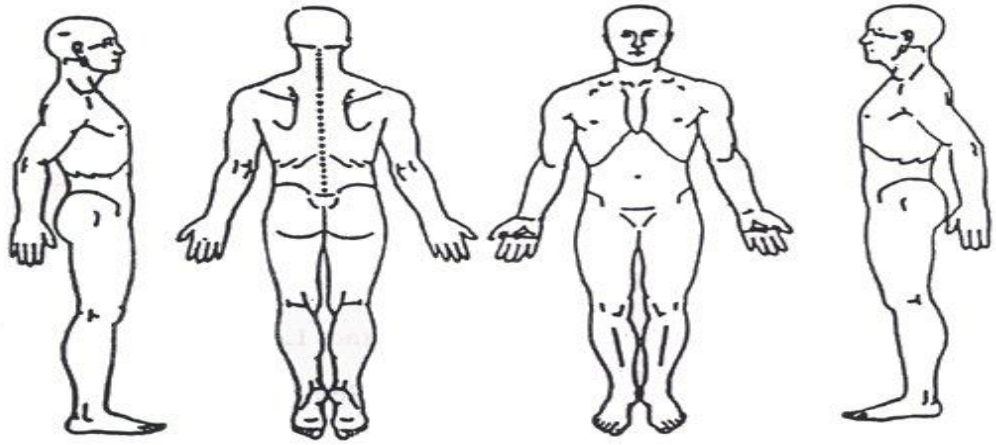
Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain):

_____

Type of pain:

☐ **S**harp ☐ **D**ull ☐ **Th**robbing ☐ **A**ching ☐ **Sh**ooting
☐ **B**urning ☐ **N**umbness ☐ **T**ingling ☐ **St**iffness ☐ **O**ther

Please mark or circle the area(s) of complaint today.



How often do you have this pain? ☐ < 25% ☐ 25-50% ☐ 50-75% ☐ 75+%

What does pain interfere with? ☐ Work ☐ Sleep ☐ Recreation ☐ Daily Activities

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Lifting ☐ Other _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage and will be subjected to additional fees should I not provide the correct insurance information. Providing incorrect information/insurance causes Richmond Chiropractic Center additional fees when billing your insurance company. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due to and payable. Fees are payable at the time of examinations and treatments are received unless other arrangements are made in advanced.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____