LOEBIG CHIROPRACTIC & REHAB NEW PATIENT INFORMATION

Today's Date ____/____/____Which Dr. are you seeing today? Dr. Loebig _____ Dr. Youngberg: _____

Patient Name_____ DOB ____/____/____ Age _____
Last, First, MI

Address _____
Street City State Zip

Home Phone _____-_____-_____ Work Phone _____-_____-_____ Cell ____-_____-_____

Patient SS# _____-_____-_____ Marital Status _____ E-mail_____

Employer _____Occupation _____Employer Phone _____-_____-_____

Referred By _____ Current Weight: _____ Height: _____

Referral ☐ Internet ☐ Newspaper ☐ Event ☐ Other _____

Spouse's Name _____ DOB ____/____/____
Last, First, MI

IN CASE OF AN EMERGENCY

Name _____ Relationship _____

Home Phone _____-_____-_____ Cell Phone _____-_____-_____

INSURANCE

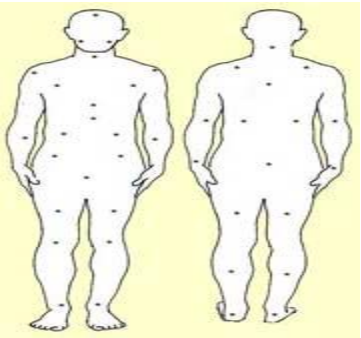
Primary Insurance_____ Policy # _____Group #_____

Name of Insured _____ Relationship _____

DOB of Insured _____ Gender of Insured _____

PATIENT HISTORY

Please mark the exact location of your pain on the diagram below. Also, describe the type and frequency of your pain.
i.e. dull, sharp, constant, off and on, etc…***Also please state if problem is getting better, worse or staying the same.***



_____
_____
_____
_____
_____

How did this condition develop? (What caused it? When where you first aware of it?) _____
_____

Have you ever had this problem or similar problems before? **Y or N** Explain: _____

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY AND INSURANCE ASSIGNMENT FORM

Patient Name: _____

I consent to treatment as necessary or desirable to the patient first named above, including but restricted to whatever chiropractic manipulation, therapies supplements, supplies, conduct of x-ray or other studies that may be used by the attending doctor, office associates or chiropractic assistants. I acknowledge full responsibility for payment of such services and/or supplies and agree to pay for them in full, at the time of service/visit, unless other written arrangements are made in advance. Should my account become due in excess of 60 days from billing and then the account is turned over to an collection agency or attorney for collection, I understand that I am liable for all collection and attorney's fees which amount to not less than one-third of the total amount due, plus other costs of collections.

Insurance Assignment: **Please Initial**

_____ I hereby authorize payment of medical insurance benefits to be payable to Loebig Chiropractic & Rehab, also to include Dr. Glenn M. Loebig.

_____ I authorize the release of any medical information necessary to process any claim.

Signature: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Loebig Chiropractic to use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Loebig reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Glenn Loebig, D.C., Box 640, Great Falls, Virginia 22066.

With this consent, Dr. Glenn Loebig or his staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO (typical practice operations), such as appointment reminders, insurance items and any calls pertaining to my clinical care

With this consent, Dr. Glenn Loebig or his staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Dr. Glenn Loebig or his staff may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Glenn Loebig restrict how it uses or discloses my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Loebig may decline to provide treatment to me.

Signature: _____ Date: _____

CANCELLATION POLICY

Chiropractic appointments that you are unable to keep must be cancelled or rescheduled within at least 6 hours prior or a $25.00 late cancellation fee will be applied to your account. If you do not show for your appointment, a $50.00 no show fee will be applied to your account.

Massage/Acupuncture/Nutrition/Allergy appointments, which you are unable to keep, must be cancelled or rescheduled within at least 6 hours or full price will be applied to your account.

Late cancellation/no show appointment fees are not reimbursable by your insurance company and will be payable on your next visit.

Please check with the front staff for Chiropractic, Massage, and Acupuncture hours, rates, and availability of appointments.

Patient Signature: _____ Date: _____

Informed Consent:

How safe is Chiropractic Care?

"Chiropractic is widely recognized as one of the safest drug-free, non-invasive therapies available for the treatment of back pain, neck pain, joint pain of the arms or legs, headaches, and other neuromusculoskeletal complaints. Although chiropractic has an excellent safety record, no health treatment is completely free of potential adverse effects. The risks associated with chiropractic, however, are very small. Many patients feel immediate relief following chiropractic treatment, but some may sometimes experience mild soreness or aching, just as they do after some forms of exercise. Current literature shows that minor discomfort or soreness following spinal manipulation typically fades within 24 hours.

In addition to being a safe form of treatment, spinal manipulation is incredible effective, getting patients back on their feet faster than traditional medical care. A March 2004 study in the Journal of Manipulative and Physiological Therapeutics found that chiropractic care is more effective than medical care at treating chronic low-back pain in those patients who have been experiencing the symptoms for one year or less. In addition, a study published in the July 15, 2003, edition of the journal Spine found that manual manipulation provides better short-term relief of chronic spinal pain than a variety of medications.

Neck Adjustments

Neck pain and some types of headaches are sometimes treated through neck adjustment. Neck adjustment, often called cervical manipulation, works to improve joint mobility in the neck, restoring range of motion and reducing muscle spasm, which helps relieve pressure and tension. Neck adjustment is a precise procedure that is generally applied by hand to the joints of the neck. Patients typically notice a reduction in pain, soreness, stiffness, and an improved ability to move the neck.

Neck manipulation is a remarkable safe procedure. Although some reports have associated upper high-velocity neck manipulation with a certain kind of stroke, or vertebral artery dissection, there is not yet a clear understanding of the connection. While we don't know the actual incidence of stroke associated with high-velocity upper neck manipulation, the occurrence appears to be rare-1 in 5.85 million manipulations-based on the clinical reports and scientific studies to date. To put this risk into perspective, if you drive more than a mile to get to your chiropractic appointment, you are at greater risk of serious injury from a car accident than from your chiropractic visit.

It has also been suggested that sudden, sever upper-neck pain and/or headache, which may indicate a pre-stroke condition, could cause someone to visit a doctor of chiropractic. In addition, some common activities, such as stargazing, rapidly turning the head while driving, and having a shampoo in a hair salon may cause an aneurysm—a widening of an artery resulting from the weakening of the artery walls—of the neck arteries, resulting in stroke. Such events remain very difficult to predict.

It is important for patients to understand the risks associated with some of the most common treatments for neck and back pain—prescription non-steroidal anti-inflammatory drugs (NSAIDS)—as these options may carry risks significantly greater than those of manipulation. According to a study from the American Journal of Gastroenterology, approximately one-third of all hospitalizations and deaths related to gastrointestinal bleeding can be attributed to the use of aspirin or NSAID painkillers like ibuprofen.

Furthermore, surgery for conditions for which manipulation may also be used carries risks many times greater than those of chiropractic treatment. Even prolonged bed rest carries some risks, including muscle atrophy, cardiopulmonary deconditioning, bone mineral loss and thromoembolism.

If you are visiting your doctor of chiropractic with upper-neck pain or headache, be very specific about your symptoms. This will help your doctor offer the safest and most effective treatment, even if it involves referral to another health care provider. If the issue of stroke concerns you, do not hesitate to discuss it with your doctor of chiropractic. Depending on your clinical condition, he or she can forego manipulation, and instead can recommend joint mobilization, therapeutic exercise, soft-tissue techniques, or other therapies.

Research Ongoing

The ACA believes that patients have the right to know about the health risks associated with any type of treatment, including chiropractic. Today, chiropractic researchers are involved in studying the benefits and risks of spinal adjustment in the treatment of neck and back pain through clinical trials, literature reviews and publishing papers reviewing the risks and complications of neck adjustment.

All Available evidence demonstrates that chiropractic treatment holds an extremely small risk. The chiropractic profession takes this issue very seriously and engages in training and postgraduate education courses to recognize the risk factors in patients, and to continue rendering treatment in the most effective and responsible manner."

I _____ (name) have read and understand the above informed consent and I authorize the doctor to persist with treatment has he/she deems medically necessary.

_____ _____
Signature Date

Additional Information can be found at www.acatoday.org.
This patient information pages is a public service of the Journal of the American Chiropractic Associate.

PATIENT HISTORY

Have you ever received any treatment for this condition? **Y or N** If yes, where, when and what were the results? _____
_____Any medical diagnosis of your complaint: **Y or N** Explain: _____
Any chiropractor consulted in the past? (Name) _____ (Date Consulted) ___/___/___
For what problem(s)? _____ Please give your history of all x-rays (medical) taken.
(Specify date/type) _____
Have you ever been in an automobile accident? **Y or N** When? ___/___/___
Any other accidents, falls, etc. that may have caused your problem: _____
Please give your history of all x-rays (medical) taken. (Specify date/type) _____
Do you eat balanced meals which contain one of each of the 4 basic food groups (milk, bread, meat, fruit and vegetables)?
_____ Do you take vitamins? _____
List any sport(s) you play: _____ Hours per week: _____
Do you experience any clicking noises or pain in your jaw while eating or opening your mouth? Y or N
Are you presently using any back or arch supports, orthotics, heel lifts, or braces of any kind? Y or N
Describe: _____
Date of last Menstrual Period: ___/___/___ Are you pregnant? _____

Race: ❑ White ❑African American ❑Asian ❑ Am Indian or AK Native ❑Native Hawaiian or other Pacific Islander ❑Decline
Ethnicity: ❑Non-Hispanic or Latino ❑Hispanic or Latino ❑Decline
Preferred Language: ❑English ❑Spanish ❑Portuguese ❑Italian ❑French ❑Chinese ❑Russian ❑Japanese
Preferred Contact: ❑Phone ❑Email ❑Text ❑Fax ❑Postal Mail ❑Other: _____

Medical Care Information			
Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you had surgeries in the last 5 Years: ☐ Yes ☐ No If yes, Last Surgery Date:			
Reason for Surgery:			

Present Illness/ Condition:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	

Other:

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	☐ Ulcer
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Polio
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Scoliosis
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Diverticulitis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	

Other:

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Misc.:

Smoking

❑ Current every day smoker ❑Current some day smoker ❑Former smoker ❑ Never

Medication Allergies

☐ ACE Inhibitors	☐ Cephalosporin's	☐ HMG-COA Reductase Inhibitors	☐ Macrolides	☐ Paxil	☐Sertraline Derivatives
☐ Amoxicillin	☐ Cipro	☐ Ibuprofen	☐ Mepridine	☐ Penicillin	☐ Sulfa
☐ Aspirin	☐ Codeine	☐ Iodine	☐ Metronidazole	☐ Percocet	☐ Tetracycline
☐ Bactrim	☐ Darvon	☐ Keflex	☐ Morphine	☐ Pravachol	☐ Ultram
☐ Benadryl	☐ Demerol	☐ Levaquin	☐ NSAIDS	☐ Propoxyphene	☐ Zestril
☐ Biaxin	☐Erythromycin	☐ Lipitor	☐ Opioid Analgesics	☐ Quinolones	☐ Zocor
☐ Cefaclor	☐Flagyl	☐Lisinopril	☐ Peroxitine Derivatives	☐ Salicylates	☐ Zoloft

Other:
What are the reactions you face? (i.e. - Hives, Rash, etc.)

Medications					
Medication Name	**Dose**	**Form**	**Route**	**Frequency**	**Date Started**
E.G. Zyrtec	10 mg	Tablet	By mouth	once per day	10/24/2008

- -

DOCTOR'S NOTES (DO NOT WRITE BELOW THIS LINE)

Chief Complaint: ____

Date of Onset: ________________________________Character: __________________________________

____

Mode of Onset: _____________________________Location: ____________________________________

Relation to other body functions: ____

____

Instructions: Within each section, please indicate how your current symptoms are affecting your daily living by selecting one of the options.

Self Care/Hygiene

[__] I can provide for myself on most of my personal care.
[__] I can provide for myself, but it creates extra pain.
[__] I can provide for myself, I am slow, careful, and it is painful.
[__] I manage most of my personal care, but it requires some help.
[__] In most accommodations of my daily care, I require extra help.
[__] It is to difficult to care for myself, I stay in bed and do not perform these tasks.

Communication

[__] I can communicate in a normal fashion.
[__] I can communicate, but it causes some pain.
[__] My communication abilities are normal, but always painful.
[__] My communication abilities are restricted by pain.
[__] Pain seriously limits my communication except for emergencies.
[__] Pain prevents communication abilities completely.

Normal Living - Sitting

[__] I am able to assume a sitting position for an indefinite period of time without pain.
[__] I can sit down for an indefinite period of time, but it causes some pain.
[__] I am restricted to one hour of sitting due to pain.
[__] Due to pain, I am only able to sit for 30 minutes.
[__] Pain restricts sitting for longer than 10 minutes.
[__] I am unable to sit due to pain.

Normal Living - Standing

[__] I am able to stand as long as I like without pain.
[__] I am able to stand for an indefinite period of time, but it causes pain.
[__] I am restricted to one hour of standing due to pain.
[__] Due to pain, I am only able to stand for 30 minutes.
[__] Pain restricts standing for longer than 10 minutes.
[__] I am unable to stand due to pain.

Normal Living - Lifting

[__] I am able to lift heavy objects without pain.
[__] I am able to lift heavy objects, but it causes some pain.
[__] I am unable to lift heavy objects off the floor. However, I can manage if they are at table height.
[__] Due to pain, I am not able to lift heavy objects. However, light to medium weight objects are manageable.
[__] Pain restricts lifting only very lightweight objects.
[__] I am unable to lift any objects of any weight at all.

Ambulation

[__] I am able to walk any distance without pain restrictions.
[__] I am limited to walk one mile due to pain restrictions.
[__] I am limited to ½ mile of walking due to pain.
[__] Due to pain, I am restricted to walking less than ¼ mile.
[__] I require the use of crutches or a cane to assist walking.
[__] I remain in bed most of the time due to pain.

Travel

[__] I am able to travel without pain restrictions.
[__] I am able to travel almost anywhere, but it causes pain.
[__] I can manage 2 hours of travel, but pain is present and severe.
[__] Due to pain, I am limited to less than an hour of travel time.
[__] Only short, urgent trips are possible due to pain limitations.
[__] I am restricted in travel due to pain, other than emergencies of short distances (hospital, doctor visits).

Non Specialized Hand Activities

[__] I can grasp in a normal fashion.
[__] I can utilize grip and tactile discrimination, but there is some pain.
[__] My grasp and grip capabilities are normal, but always painful.
[__] Grasping, grip strength can tactile sensations are restricted by pain.
[__] prevents grip strength, grasping and tactile discrimination completely.
[__] Pain prevents grip strength, grasping and tactile discrimination completely.

Sexual Function

[__] I am able to engage in normal sexual activities without pain.
[__] I am able to participate sexually, but it creates some pain.
[__] I engage normally in sexual activities, but it is very painful.
[__] I am restricted in sexual activities due to pain.
[__] Pain has created a near absent sex life.
[__] Due to pain, I abstain from any sexual activities.

Sleep

[__] I sleep well in a normal fashion.
[__] I sleep well at night, as long as I use sleeping pills.
[__] I fail to accomplish more than 6 hours of sleep.
[__] I fail to accomplish more than 4 hours of sleep.
[__] I fail to accomplish more than 2 hours of sleep.
[__] Pain prevents sleep.

Social & Recreational Activities

[__] I am enjoying a normal, active social life without pain restrictions.
[__] The presence of pain affects only the more energetic activities of my social life (bowling, golfing, sports, etc.).
[__] I participate in a normal social life, but pain is increased during most activities.
[__] Pain restricts all of my social activities; therefore, I do not go as often.
[__] I am restricted to social activities at home due to pain.
[__] Due to pain, I do not participate in any social activities.

The Effects Of Medication

[__] I am able to tolerate pain; therefore, I do not use any pain medication.
[__] I use pain medication and experience complete relief from pain.
[__] I use pain medication and experience moderate relief from pain.
[__] Pain medication offers only very little relief from pain.
[__] Pain medication fails to offer relief; therefore, I no longer take them. ** IF taking medications please indicate which ones and dosage: _____
_____*A*
ny Allergic reactions to medications: _____
_____

Pain Intensity

[__] My pain is MINIMAL and tolerated, it is annoying, but does not limit my physical performance.
[__] Pain is SLIGHT and tolerated; it causes some limitations on my physical performance.
[__] I experience MODERATE pain, which causes a significant limitation on my physical performance of activities.
[__] I experience SEVERE pain, which reduces my capability to perform any activity.

Pain Frequency

[__] I have INTERMITTENT symptoms occurring less than 25% of my wake time.
[__] I experience OCCASIONAL symptoms between 25% and 50% of my wake time.
[__] Pain is FREQUENT, and occurs between 50% and 75% of my wake time.
[__] I have CONSTANT pain occurring between 75% and 100% of my wake time.