PATIENT REGISTRATION

PATIENT INFORMATION

Date_____ File # _____

Patient Name_____

Address_____

City_____

State_____ Zip_____

Sex: ☐ Male ☐ Female SS#:_____

Birthdate:_____ Age_____

Name of family physician_____

May we contact them regarding your health? ☐ Yes ☐ No

Would you like to electronically access to your health records? ☐ Yes ☐ No

CONTACT INFORMATION

Parent or Guardian _____

Relationship _____ Phone _____

ACCIDENT INFORMATION

Injury due to an accident? ☐ Yes ☐ No

If yes, Date of accident _____

Type of accident ☐ Auto ☐ Home ☐ Other _____

Have you made a report of your accident? ☐ Yes ☐ No

To Whom? ☐ Auto Insurance ☐ Other _____

Attorney Name (if applicable)_____

ELECTRONIC HEALTH RECORD REPORTING (Per Federal Requirements)

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Two or more

Preferred language: ☐ English ☐ Spanish ☐ French ☐ German ☐ Italian ☐ Mandarin ☐ Cantonese ☐ Japanese ☐ Tagalog ☐ Other _____

Preferred contact method: ☐ Call cell ☐ Text cell ☐ Call home ☐ Call work ☐ Email ☐ Fax (_____)

PATIENT CONDITION (HPI)

Reason for visit:_____

When did symptoms start? _____ How did problem start? _____

If you have pain, rate your pain level (circle one):

0 1 2 3 4 5 6 7 8 9 10

No Pain ***Severe Pain***

Is your pain: ☐ Constant **(100% of day)** ☐ Frequent **(75% of day)** ☐ Occasional **(50% of day)** ☐ Intermittent **(25% of day)**

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS *please check ☑ any that apply to you*

Constitutional
- ☐ Bad general health
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

Eyes
- ☐ Eye disease/injury
- ☐ Glasses or contact lens
- ☐ Blurred / double vision

Ear, Nose, Throat
- ☐ Hard of Hearing
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat / voice change
- ☐ Swollen glands

Musculoskeletal
- ☐ Joint Pain / Stiffness
- ☐ Joint Swelling
- ☐ Chronic fatigue
- ☐ Fibromyalgia

Cardiovascular
- ☐ Chest pain / Palpitations
- ☐ Dizziness / Fainting
- ☐ Shortness of breath
- ☐ Swelling in hands / feet
- ☐ High blood pressure
- ☐ High cholesterol

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Diarrhea/Constipation

Neurological
- ☐ Seizures or Epilepsy
- ☐ Numbness / Tingling

Genito-urinary
- ☐ Pain / Difficulty urinating
- ☐ Kidney stones
- ☐ Kidney problems

Respiratory
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing / Asthma
- ☐ Pneumonia

Psychiatric
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty sleeping
- ☐ ADHD

Integumentary (skin, breast)
- ☐ Rash / Sores
- ☐ Lesions
- ☐ Dermatitis / Eczema

Hematologic/Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleed or bruise easily
- ☐ Anemia
- ☐ Enlarged glands

Endocrine
- ☐ Excessive thirst / urination
- ☐ Heat or cold intolerance
- ☐ Skin becoming drier
- ☐ Diabetes
- ☐ Thyroid disorder

Allergic/Immunologic
- ☐ Food allergies
- ☐ Airborne allergies
- ☐ Systemic Lupus

If 14 or over: Tobacco Use
- ☐ Yes
- ☐ No

PATIENT NAME: **FILE #:**

FAMILY HISTORY

	Living?		Rheum Arthritis		Heart Problems		Diabetes		Asthma		Cancer		Back Problems	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brothers/Sisters	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HOSPITALIZATIONS AND SURGERIES

Fractures _____ Hospitalizations_____

Surgeries_____

PRESCRIBED MEDICATIONS

Name of drug	Quantity	Strength (10 mg, 25 mg, etc.)	Dose form (tablet, aerosol, etc.)	Instructions (1/day, etc)

Are you allergic to any medications? ☐ No ☐ Yes (if yes, list name and symptoms) _____

_____

List any vitamins or supplements you take _____

__

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the clinic any changes in my medical status.

_____ _____ **Reviewed by:**_____

Signature of Parent or Guardian of Minor **Date**

Name_____**Date**_____

CONSENT TO TREATMENT OF MINOR CHILD

Lake Spine Specialists
9031 Mentor Avenue
Mentor, OH 44060
(440) 255-1315

I hereby authorize Dr. Lemire and whomever he may designate as assistants to administer chiropractic care as deemed necessary to my _____ (indicate relationship to child), _____.
(Name of Child)

Dated at _____ in _____, _____ this _____ day of _____, 20_____.
(Time) (City) (State)

Signed: _____
(Parent/Guardian)

Witness: _____

Neck Disability Index (Vernon - Minor)

This questionnaire will give your doctor information about how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section the '***ONE'*** box that applies to you. We realize you may consider that two of the statements in any section may apply, but please mark the box that ***most closely*** describes your present-day situation.

Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive as long as I want with slight pain in my neck.
- ☐ I can drive as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all due to severe pain in my neck.
- ☐ I cannot drive my car at all.

Reading

- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want due to moderate neck pain.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor. I can manage if items are conveniently positioned, i.e., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Recreation

- ☐ I can engage in all my recreation activities with no neck pain.
- ☐ I am able to engage in all my recreation activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I can't do any recreation activities at all.

Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

Concentration

- ☐ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want.
- ☐ I have a lot of difficulty in concentrating when I want.
- ☐ I have a great deal of difficulty in concentrating when I want.
- ☐ I cannot concentrate at all.

Work

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

SCORE:_____

Pain Severity Scale: Rate the severity of your pain **today** by checking one box on the following scale

No pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Excruciating pain**

Name_____ **Date**_____

Low Back Pain and Disability Questionnaire (Revised Oswestry)

This questionnaire will give your doctor information about how your back condition affects your everyday life. Please answer every section and mark in each section the '***ONE'*** box that applies to you. We realize you may consider that two of the statements in any section may apply, but please mark the box that ***most closely*** describes your present-day situation.

Pain Intensity

- ☐ My pain is mild to moderate. I do not need pain killers.
- ☐ My pain is bad, but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain.

Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Lifting

- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor. I can manage if items are conveniently positioned, i.e., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit in my favorite chair only, but for as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Walking

- ☐ I can walk as far as I wish.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can walk only if I use a cane or crutches.
- ☐ I am in bed or in a chair most of the time.

Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself normally, and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I sleep well, but only when taking medication.
- ☐ Even when I take medication, I sleep less than 6 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to necessary journeys under ½ hour.
- ☐ Pain prevents travelling except to the doctor/hospital.

Social Life

- ☐ Social life is normal and gives me no pain.
- ☐ Social life is normal, but increases the degree of pain.
- ☐ Pain affects my social life by limiting my more energetic interests, i.e., dancing, sports, etc..
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

SCORE:_____

Pain Severity Scale: Rate the severity of your pain **today** by checking one box on the following scale

No pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Excruciating pain**

INFORMED CONSENT

I understand that Lake Spine Specialists performs manual therapy techniques, physical therapy procedures, exercise and acupuncture as part of its treatment protocol. Although chiropractic care is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that any form of treatment has potential risks and complications associated with it:

Risks of Chiropractic Treatment

Soreness: Like exercise, it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea may occur, but are relatively rare.
Rib/Joint Injury: This may include rib fracture or rib cartilage sprain. Conditions like physical defects, osteoporosis, or arthritis may increase this risk. Treatment precautions are taken to minimize the risk.
Stroke: While strokes can happen from a multitude of factors, strokes from chiropractic adjustments are rare and no greater than the general medical population. Studies estimate the risk at 1:1 million to 1:5 million. *(Journal of the CCA Vol 27, No.2 June, 1993).* Risk is decreased by minimizing neck rotation. That is the protocol we utilize in our clinic.
Burns: Some electric therapies generate heat and may cause a burn, resulting in a temporary increase of pain and possible blistering. Our machines are calibrated regularly, and individual patient pads are used.

Risks of Acupuncture Treatment

Drowsiness: may occur after treatment (infrequently). If affected, you are advised not to drive
Minor bleeding/bruising: may occur after acupuncture (~3% of patients) or during cosmetic procedures
Pain: during treatment may occur (~1% of patients);
Increase in Symptoms: Worsening after treatment (< 3% of patients). You should tell your doctor about this, but it is usually a good sign that acupuncture will be beneficial
Fainting: Can occur in certain patients, particularly at the first treatment.
Pneumothorax: This may occur when treating points over the lung.
Infection: (rare). We use pre-sterilized, one-time-use, disposable needles to reduce this risk.

Alternative Treatment Options & Risks

Reasonable alternatives and risks to these procedures are available to me. They include:
Medications: These can reduce pain or inflammation. Long-term use/overuse of drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, pain, reaction to anesthesia, prolonged recovery, serious complications or death.
Rest/Exercise: Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed-rest contributes to weakened bones and joint stiffness. Exercises alone are of limited value but do not correct injured nerve and joint tissues.
Non-treatment: Neglecting care can increase pain, accelerate degeneration, cause nerve damage, increase inflammation, and worsen pathology. This may complicate treatment, making it more difficult and less effective the longer it is postponed.

Treatment Results

I realize that the practice of medicine, including chiropractic, is not an exact science. I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to apply to all my present and future treatments at this clinic.

_____	_____	_____
Signature of Patient	Date	Staff Initials

Assignment of Benefits for Lake Spine Specialists

RELEASE OF INFORMATION: I certify the information contained herein to be true and correct to the best of my knowledge. I hereby authorize Lake Spine Specialists to release any and all information concerning my care and treatment to the Insurance Companies, Employers, Attorneys, Benefit Plans, Workers Compensation and/or Managed Care Organizations (MCO).

ASSIGNMENT OF INSURANCE BENEFITS: In consideration of services received or to be received by the patient, patient assigns to Lake Spine Specialists all insurance benefits which patient may be entitled to receive, not to exceed the charges for such services. Patient further warrants that such benefits are or will be justly owing to the patient that no part of same has been assigned or encumbered, and that Lake Spine Specialists shall be entitled to the full amount of the charges from same without setoff. This assignment shall be irrevocable. Patient hereby guarantees payment of any and all charges not covered by this assignment and waives any and all notices and demands in the event of non-payment thereunder.

PERSONAL INJURY MATTERS: If I have been injured by or as a result of an act of omission of another person, entity or thing, such injury(ies) is/are being treated by Lake Spine Specialists and I seek recovery from a third party for such injury ("Personal Injury Matter"), I will disclose this to Lake Spine Specialists with the name of my attorney, if any. If, in addition to the personal injury matter, I shall also seek recovery of damages for the same injury under my health insurance, the Personal Injury Matter shall be considered primary and the health insurance claim shall be secondary with respect to reimbursement and payment of Lake Spine Specialists' services. Lake Spine Specialists agrees to apply all fees received from my health insurance, if any, against fees for services performed with respect to the injury resulting from the Personal Injury Matter. I understand, acknowledge and agree that the balance of Thomas Lemire DC LLC's fees not paid by my health insurance shall be paid from any monetary recovery of damages recovered by me in connection with the Personal Injury Matter. In addition, I irrevocably assign to Lake Spine Specialists any monetary recovery of damages recovered in connection with the Personal Injury Matter, not to exceed Lake Spine Specialists' charges for services in connection with such injuries. If, after Lake Spine Specialists receives payment in full, Lake Spine Specialists receives payment from my health insurance in connection with those injuries sustained from the Personal Injury Matter, then Lake Spine Specialists will reimburse that amount. This paragraph is in addition to the other terms of this Assignment and shall not otherwise affect or waive the terms of this assignment, except as stated herein.

SUBROGATION MATTERS: Matters concerning subrogation between your health care insurer and your personal injury claims are the responsibility of you or your attorney for any reimbursement of funds to the appropriate parties.

The undersigned patient is also informed that returned checks are subject to service charges on any outstanding balance over 90 days and may also be subject to monthly service charges. I understand that I will be responsible for any costs for collection, including attorney fees, court costs, agency fees, up to thirty-five (35%) percent of my outstanding balance, due to nonpayment of services rendered.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from my healthcare provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

DATE:_____ SIGNATURE:_____

WITNESS:_____

Lake Spine Specialists

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Lake Spine Specialists.

I understand that the Notice describes the uses and disclosures of my protected health information by Lake Spine Specialists and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement

Communications barriers prohibited obtaining the acknowledgement

Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*