CONFIDENTIAL PRACTICE MEMBER INFORMATION - PEDIATRIC

Dr. Loriann Laugle
www.DoctorLoriann.com

Date: _____

IS VISIT ACCIDENT RELATED? ____ Yes ____ No
(If YES, please notify the receptionist)

Patient Name _____

Mailing address _____ City _____ State ___ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Parent email address _____ May we add you to our e-mail list? ___ Yes ___ No

Age ____ Birth Date _____ Sex _____

Occupation _____ Employer _____

Name of Parent(s) _____

Parent's Occupation _____ Employer _____

Parent's Phone Number _____

Name and Ages of Other Children _____

Emergency Contact Name & Phone Number _____

Whom may we thank for referring you to us? _____

REASON FOR THIS APPOINTMENT

What concerns do you feel Dr. Loriann can address for your child?_____

_____

Are these concerns affecting quality of life?

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

Date symptoms appeared or accident happened: _____

Ever had a similar condition? _____ Yes ____ No If Yes, when and describe_____

_____

Ever received chiropractic care? ❑Y ❑ N Name of D.C._____

How long under care? ❑ _____days ❑_____weeks ❑_____ months ❑ years_____
Date of last visit: _____Why did you stop?_____

_____

Have you consulted or do you regularly consult any of the following providers? (Check all that apply.)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason why: _____

_____

FOR FEMALE

Are you pregnant? Y N Date of last menstrual period: _____

If x-rays are recommended, your signature is required (below) to indicate that you are **not pregnant**.

Signature: _____Date:_____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife _____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

HEALTH, WELLNESS & CHIROPRACTIC CARE

The primary system in the physical body which coordinates health is the CENTRAL NERVOUS SYSTEM. The vertebrae, (bones of the spinal column) surround and protect the delicate NERVOUS SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE & NERVOUS SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to and ***how they may relate to your present spinal, nerve and health status.***

PHYSICAL STRESS: BIRTH & INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please indicate where and how your child was birthed.

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps
❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that your child has experienced.

Any **accidents or injuries** related to any of the following? (Check all that apply.)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state ***type of injury and date:***_____

_____

Ever **hurt/injured** spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? ❑ Y ❑ N

If yes, state ***type of injury and date:***

_____

_____

Ever **hurt, broken, fractured or sprained** any bones or joints? ❑ Y ❑ N If yes, list ***body parts injured and dates:***

_____

_____

Ever been hospitalized? Please include any surgeries. ❑ Y ❑ N If yes, ***state reason and dates:***

_____

_____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has experienced any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.)
The following will reveal exposures your child may have had.

Is your child **vaccinated?** ❑ Y ❑ N If yes, did he/she have a **reaction**? ❑ Y ❑ N

Been **exposed to** any of the following on a regular basis, (past or present)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy

❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:_____

Allergies to any foods? ❑ Y ❑ N **If yes, please list:** _____

_____

Does your child **consume** any of the following presently?

❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter: _____

_____

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE

Child's **physical health**?	❑ Good	❑ Fair	❑ Poor
Child's **emotional/mental health**?	❑ Good	❑ Fair	❑ Poor
Child's overall **"quality of life"**?	❑ Good	❑ Fair	❑ Poor

List Sports/Activities/Musical instruments _____

Do you follow a **special dietary regime**? If yes, what? _____

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)

❒ Relief of a symptom or problem

❒ Relief and prevention of a symptom or problem

❒ Healthier spine and nerve system

❒ Optimal health on all levels (emotional, physical, chemical, etc)

PLEASE READ & SIGN BELOW

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give Dr. Loriann Laugle permission to render care to my child. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any care that is determined to be clinically necessary and mutually agreed upon.

Parent or Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

Chemical Balance Questionnaire

Name:_____Date:_____

Speed of healing is determined by **chemical balance** in the body. Chemical balance is determined, in large, by **what you eat.** Please indicate the amounts and frequencies you partake in the following **(BE HONEST!)**

***NOTE:** YOU DO NOT HAVE TO COMPLETE BOTH "PER DAY" AND "PER WEEK" COLUMNS. SIMPLY, INDICATE THE AMOUNT UNDER WHICHEVER COLUMN IS BETTER SUITED FOR YOU.

	Per Day*	Per Week*
1. Coffee / Tea (caff/decaff)	_____ cups	_____ cups
2. Red meat (beef, pork, bacon, ham, etc.)	_____ servings	_____ servings
3. Chicken/fish	_____ servings	_____ servings
4. Consume dairy?	YES / NO	
5. Water	_____ glasses/oz	
6. Fresh fruits	_____ servings	_____ servings
7. Fresh vegetables (non-canned)	_____ servings	_____ servings
8. Pasta, breads / refined grains (made with white flour)	_____ servings	_____ servings
9. Whole grains	_____ servings	_____ servings
10. Consume artificially sweetened products? (Splenda, Sweet-N-Low, Equal, Aspartame, etc.)	YES / NO	
11. Fast Food (McDonalds, Wendy's, etc.)	_____ times	_____ times
12. Fats (nuts, avocado, coconut, oils, etc.)	_____ times	_____ times
13. Processed Foods (cereals, boxed or frozen meals)	_____ times	_____ times
14. Alcoholic beverages	_____ servings	_____ servings
15. Soft drinks (regular/caffeine-free)	_____ oz	_____ oz
Diet Soda	_____ oz	_____ oz
16. Smoking	_____ packs	_____ packs

Cravings (circle ones that apply): salt sugar chocolate bitter carbs/starches ice sour/vinegar

What is a typical breakfast for you? _____

What is a typical lunch for you? _____

What is a typical evening meal for you? _____

List any vitamins/herbs/supplements you are currently taking _____
_____

Major life changes (divorce, losses, trauma, etc.): _____
_____

Name _____Date _____

Review of Systems

Check any item that applies to patient's ***current*** health:

General
- Weight loss ___
- Fever ___
- Fatigue ___

Eyes
- Glasses /contact lenses ___
- Blurred vision ___
- Eye pain ___
- Eye discomfort ___

ENT
- Ear pain ___
- Nosebleeds ___
- Sore throat ___
- Hoarseness ___
- Nasal Stuffiness ___

Cardiovascular
- Heart Murmur ___
- Irregular Heart Beat ___
- Chest Pain ___
- Fainting Spells ___
- Blood Pressure Problems ___

Skin
- Rashes ___
- Sores ___
- Itching/Burning ___

Respiratory
- Cough ___
- Wheezing ___
- Shortness of breath ___
- Apnea ___

Endocrine
- Loss of Hair ___
- Heat/Cold Intolerance ___
- Poor Growth ___
- Thyroid Problems ___

Hematology
- Bleeding Problems ___
- Anemia ___
- Easy Bruising ___
- Enlarged Glands ___

Genitourinary
- Pain with urination ___
- Blood in urine ___
- Increased urine frequency ___
- Abnormal discharge ___
- Urinary tract infection ___

Musculoskeletal
- Joint pain/swelling ___
- Weakness ___
- Muscle Pain ___

Neurological
- Headaches ___
- Seizures ___
- Dizziness ___
- Developmental Delays ___

Gastrointestinal
- Constipation ___
- Diarrhea ___
- Heartburn ___
- Blood in stool ___
- Abdominal pain ___
- Vomiting ___

Allergy
- Hives/Eczema ___
- Hayfever ___
- Medication allergies ___
- Food ___

Women only:
- Painful period ___
- Excessive flow ___
- Irregular cycles ___
- Vaginal burning/itching ___
- Hot flashes ___

Men only:
- Testicular problems ___
- Prostate problems ___

Past conditions of patient and immediate family

Patient (P) / Family member (F)

- __/__ Anemia
- __/__ Asthma
- __/__ Cancer/Tumors
- __/__ Diabetes
- __/__ Depression
- __/__ Epilepsy/Seizures
- __/__ Heart Disease
- __/__ High Blood Pressure
- __/__ Liver Disease
- __/__ Hepatitis
- __/__ Kidney Disease
- __/__ Lung Disease
- __/__ Arthritis
- __/__ Stroke
- __/__ Thyroid Disease
- __/__ Infectious Diseases
- __/__ GI Disease
- __/__ High Cholesterol
- __/__ HIV/Immune Disease
- __/__ Other

Patient Health Information Consent Form – Part 1

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information (PHI) we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

Our office reserves the right to amend the terms of our HIPAA NOTICE.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

Print Name of Patient:_____

Signature: _____Date:_____

Patient Health Information Consent Form – Part 2

The following office procedures allow our office to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below, you are giving us authorization to follow through with these procedures. Should you desire something not be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including email) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- We would like to be able to refer others to speak with you about your experience with Dr. Loriann Laugle.
- We often take photos of our practice members/patients and post them in the office, newsletters and on social media.

You have the right to refuse any part of this authorization without affecting your care or the relationship with Dr. Loriann Laugle.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Your signature indicates your authorization of these activities (unless crossed out and initialed).

Print Name of Patient: _____

Signature: _____ Date: _____

Financial Policy

It is important to us that you read and understand our financial policy as it relates to your particular situation.

1. Patients without Insurance (Cash Pay)

Payment is expected at the time of service. We accept cash, personal checks, Mastercard and Visa.

2. Group or Individual Health Insurance

Dr. Laugle has decided to **invest more time, money and energy in direct patient care** and is currently an out-of-network provider. Most insurance companies cover only spinal manipulation and select adjunct therapies for acute or medically necessary cases. While that's a very valuable service to provide, Dr. Loriann's specialty is **whole being wellness**, which is not covered by insurance.

If your condition qualifies and based on your insurance policy, you may be eligible for out-of-network reimbursement. You must **call to verify** your health insurance benefits using our **Health Insurance Verification Form**. The benefits quoted to you by your insurance company are not a guarantee of payment.

We do not directly bill insurance for services provided. We will however provide you with a receipt/superbill that includes diagnosis codes to assist you with possible insurance reimbursement. Insurance policies are an agreement between the policy-holder and the carrier– any and all insurance questions should be directed to the appropriate party.

We absolutely understand financial hardships and are willing to work with patients *who are dedicated and invested in themselves* to make positive changes to reach their health goals. If you are concerned with the financial investment and are interested in our wellness center, please discuss with us.

Family plans available upon request.

3. Automobile Accidents

Please notify your auto insurance carrier of your visit to our office immediately, and complete our Accident Injury Insurance Information Form according to the Med Pay portion of your automobile insurance. This form must be returned to our office by the 2nd visit, or you will be considered a Cash Pay patient. We do not file to at-fault payers. If you do not go through your Med Pay, you are expected to pay at time of service

I have read and understand and agree to the Financial Policy. I understand that my insurance is an arrangement between me and my insurance company, **NOT** between Dr. Loriann Laugle and my insurance company. If necessary, I request that Dr. Loriann Laugle file insurance claims on my behalf.

Print Name of Patient:_____

Signature: _____Date:_____

Patient signature (or guardian if patient is a minor)