



# Your Facts

C1

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Apartment #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**How did you find us?** Patient (*who*): \_\_\_\_\_ Doctor (*who*): \_\_\_\_\_ Staff (*who*): \_\_\_\_\_

(*circle one*) Promotion/Event Internet Newspaper Signage Business Insurance Other: \_\_\_\_\_

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Gender** (*circle one*): Male Female **Marital Status** (*circle one*): M D W S

**Employer:** \_\_\_\_\_ **Work #:** \_\_\_\_\_ **Ext:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Primary Care Physician (PCP):** \_\_\_\_\_ **Phone # (PCP):** \_\_\_\_\_

**Are you currently taking any medications or supplements?** (*Please include regularly used over the counter medications*).....

Medication Name	Dosage and Frequency

Supplement Name	Dosage and Frequency

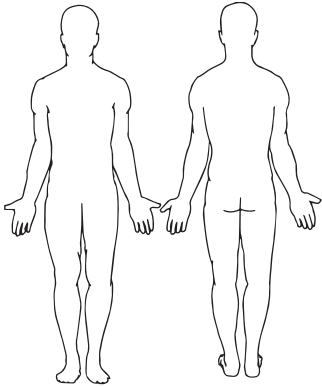
**Do you have any medication, food, or environment allergies?**

Medication, Food or Location	Reaction

**Please list 3 major health goals in order of priority:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

### Pain Location



Front

Back

### Present Condition

List conditions in order of concern and mark location of pain.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

(minor) **Pain Scale** (extreme)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

1	2	3	4	5	6	7	8	9	10

Has condition changed since onset?  Yes  No  Better  Worse

Explain: \_\_\_\_\_

What makes pain better? \_\_\_\_\_

Worse? \_\_\_\_\_

Difficult activities: \_\_\_\_\_

### Who Have You Seen:

**Who have you seen for your symptoms, and when?** **Date**

Chiropractor: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

Physical Therapist: \_\_\_\_\_

Other: \_\_\_\_\_

### Have You Had:

Blood analysis.....  Yes  No \_\_\_\_\_ When

Blood pressure check.....  Yes  No \_\_\_\_\_ When

Bone density.....  Yes  No \_\_\_\_\_ When

Eye exam.....  Yes  No \_\_\_\_\_ When

Feelings of hopelessness.....  Yes  No \_\_\_\_\_ When

Feelings of depression.....  Yes  No \_\_\_\_\_ When

Feelings of anxiety.....  Yes  No \_\_\_\_\_ When

Feelings of panic.....  Yes  No \_\_\_\_\_ When

MRI.....  Yes  No \_\_\_\_\_ When

Spinal x-ray.....  Yes  No \_\_\_\_\_ When

### Current Symptoms

- 1**
- Knee Pain
  - Leg Cramps
  - Numbness in Toes
  - Tingling in Legs
  - Weakness In Legs
  - 
  - Urinating Issues
  - Lower Back Pain
- 2**
- Ringing in Ears
  - 
  - Bladder Infections
  - Belching
  - Constipation

- 3**
- Indigestion
  - Vomiting
  - 
  - Arm Pain
  - Circulatory Problems
  - Hands Cold
  - Mid-Back Pain
  - Numbness in Fingers
  - Shortness of Breath
- 4**
- Shoulder Pain
  - Tingling in Arms

- 5**
- Back Pain
  - Dizziness
  - Hair Loss
  - Hay fever
  - Hives
  - Loss of Balance/Dizzy
  - Neck Pain/Stiffness
  - Nervousness
  - 
  - Bruise Easily
  - Diarrhea
  - Feet Cold
  - Frequent Colds
  - Hemorrhoids
- 6**

- 6**
- Loss of Smell/Taste
  - Muscle Spasms
  - Sight Sensitivity
  - Sinus Problems
  - 
  - Cold/Hot Sweats
  - Fatigue
  - Fever
  - Joints Swelling/Pain
  - Sleep Problems
- 7**
- Stress
  - Other \_\_\_\_\_
  - Other \_\_\_\_\_
  - Other \_\_\_\_\_



# Your History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Medical History											
	Self	Siblings	Mom	Dad	GPs		Self	Siblings	Mom	Dad	GPs
ADD/ADHD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immune System - Weak.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis - Type.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth Trauma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer - Type.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol - High.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addictions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Condition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall Bladder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric/Reflux/Ulcer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/contacts.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/Loss.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patterns	
<i>Mark those that apply and amount if applicable.</i>	
<b>Example:</b> Lift Weights.....	<u>3 X wk</u>
Bowel movements.....	_____
Drive a stick shift.....	_____
Eat out frequently.....	_____
Enjoy work.....	_____
Exercise.....	_____
Healthy relationships.....	_____
Lift weights.....	_____
Nicotine.....	_____
Phone work excessive.....	_____
Skip meals.....	_____
Sleep comfortably.....	_____
Sleep on stomach.....	_____
Two story residence.....	_____
Wear seat belts.....	_____
Work hours per week.....	_____

Rate Your Activities			
<i>Rate the degree of pain related to performing these activities.</i>			
	<b>None</b>	<b>Some</b>	<b>Always</b>
Climbing Stairs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving/riding in cars.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of cars.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting out of bed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the restroom.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housework.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Intercourse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking care of child.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yard work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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# Our Financial Policy

C4.1

It is the policy of this office that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments, regardless of whether or not this office accepts insurance assignment. All patients are responsible to check out with the front desk to satisfy any payment due at the time of the service.

## 1. Patients without Insurance:

All payments are expected at the time of service unless other arrangements are made with Kaitlin LaVigne, DC.

## 2. Patients with Insurance:

Deductibles, co-insurance and all co-payments, along with any services not covered by insurance are expected at the time of service. Unless other arrangement is made to delay this payment until the insurance company pays. Then the client will have 15 days to pay the balance due.

## 3. Purchase of Supplements, Supplies or Non Insurance Services:

All supplements, supplies and services not covered by insurance must be paid for at the time they are received. There are no exceptions on these items or services.

**ASSIGNMENT OF BENEFITS:** I, the undersigned, certify that I and/or my dependents have coverage with the insurance as presented to Kaitlin LaVigne, DC and assign directly to Kaitlin LaVigne, DC all benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I acknowledge and understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

**AUTHORIZATIONS:** I hereby acknowledge that I have read the above policy regarding my financial responsibility to Kaitlin LaVigne, DC for medical services and treatment provided and I agree to pay Kaitlin LaVigne, DC any balance unpaid by my insurance carrier or not covered by an insurance carrier for myself and the person named below.

This authorization shall remain in effect unless and until it is revoked by you in writing and delivered to Kaitlin LaVigne, DC at 7410 Switzer Rd, Shawnee, KS 66203.

**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS:** I consent to the use or disclosure of my medical information by Kaitlin LaVigne, DC and/or the affiliate practitioners that operate within Your Wellness Connection, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Kaitlin LaVigne, DC. I understand that diagnosis or treatment of me by Kaitlin LaVigne, DC may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. Kaitlin LaVigne, DC is not required to agree to the restrictions that I may request. However, if Kaitlin LaVigne, DC agrees to a restriction that I request, the restriction is binding on Kaitlin LaVigne, DC. I have the right to revoke this consent, in writing, at any time, except to the extent Kaitlin LaVigne, DC has taken action in reliance on this consent.

***(Continued on next page...)***



## Our Financial Policy *(continued...)*

C4.2

My "medical information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This medical information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Kaitlin LaVigne, DC's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of Your Wellness Connection.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of Kaitlin LaVigne, DC. This Notice of Privacy Practices also describes my rights and the duties of Kaitlin LaVigne, DC with respect to my medical information. Kaitlin LaVigne, DC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printer Name:** \_\_\_\_\_

**Others covered by this agreement:** \_\_\_\_\_



# Chiropractic Informed Consent

C5

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Chiropractic evaluation and treatment involves certain inherent risks. There are several benefits associated with performing an evaluation. They include: working diagnosis of present condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. They include: increased flexibility, decreased pain, decreased inflammation, better circulation; all combining to improve function in activities of daily living.

Treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, acupuncture, and exercises. Risks may include but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability. However, any increase in the current level of discomfort, or any other change in symptoms should be immediately reported to a staff member.

**Adjustment:** Spinal manipulation that involves precise impulses in a specific direction to restore normal motion and position of individual vertebrae.

**Interferential current therapy:** Small electrical impulses are used to stimulate muscles and relieve tension by reducing nerve irritation. This current promotes the secretion of natural painkillers (endorphins).

**Intersegmental traction therapy:** This therapy utilizes rollers that slowly travel the length of the spine. By stretching individual joints, it promotes increased mobility and blood flow that leads to faster healing.

**Acupuncture:** This ancient Chinese practice using the insertion of needles is used to restore proper energy flow through the body known as Chi, the vital life energy that flows through every living thing.

**Exercise:** The entire body benefits from this therapy, both physically and psychologically. Exercise improves digestion, increases energy levels and promotes the reduction of stress.

Risk factors have been reduced to the best of our ability. Please acknowledge consent with full knowledge of the nature, risks, and purpose of the evaluation and treatment program.

**Disclosure:** I have read the above information and fully understand the risks involved in such treatment. I have been given the opportunity to ask any questions. All of my concerns have been addressed to my satisfaction. I agree to fully disclose any symptoms and health problems of which I am aware throughout the treatment process and will update the chiropractor immediately should my health status change in any manor.

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Printed Name: \_\_\_\_\_