Whom may we thank for referring you to this office → ______________________________?

APPLICATION FOR CARE AT McLaughlin Chiropractic Center

Today's Date:________________ HRN: ____________________

PATIENT DEMOGRAPHICS

Name: ____________________________________ Birth Date:_____-_____-_____ Age:_______ ☐ Male ☐ Female

Address:__________________________________City:______________________________State:______Zip: ____________

E-mail Address:______________________________ Home Phone:____________________ Work Phone: ______________

Marital Status: ☐ Single ☐ Married Mobile Phone:________________________ Cell Provider for text reminders:__________

Driver's License #: ___________________________ Do you have Insurance: ☐ Yes ☐ No

Employer:__________________________________Occupation:____

Spouse's Name__________________________________Spouse's Employer: ____________________________________

Number of children and Ages: ____

Name & Number of Emergency Contact: __________________________________Relationship: ___________________

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office and rate your complaints by ***circling the number*** on a scale of **1** to **10** with **0** being no pain and **10** being the worst pain.

Primary or chief complaint: _____________________ : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaint: _________________________ : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint: ___________________________ : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint:___________________________ : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin?_________________ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

What relieves your symptoms: ____

What makes them feel worse: ____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No **How did the injury happen?** ___________________________

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes, when:**_________by whom?_______________________

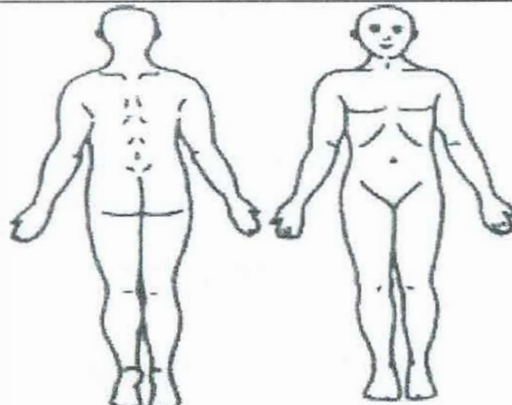
How long were you under care:_____________ What were the results? ____

Have you seen a Chiropractor in the past?: ☐ Yes ☐ No

If so, who: _______________________________

***PLEASE MARK** the areas on the diagram with the **following letters** to describe your symptoms:

R = **R**adiating **B** = **B**urning
D = **D**ull **A** = Aching
T= **T**ingling **N** = **N**umbness
S = **S**harp/ **S**tabbing



Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes** how many times? ____________________

When was the last episode? ____

How did the injury happen? ____

Other forms of treatment tried?: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: ____________________

Provided by: ____________________ How long ago? ______________ What were the results? ☐ Favorable ☐ Unfavorable

Please explain. ____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have:

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Disability ___ Cancer
___ Heart Attack ___ Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: ___________

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

Smoking: ☐cigars ☐ pipe ☐ cigarettes → How often? ☐ daily ☐ weekends ☐ occasionally ☐ never
Alcoholic Beverage(s): consumption occurs → ☐ daily ☐ weekends ☐ occasionally ☐ never
Recreational Drug(s): ☐ daily ☐ weekends ☐ occasionally ☐ never

FAMILY HISTORY:

Does anyone in your family suffer with the same conditions(s)? ☐ No ☐ Yes
If yes, whom? ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ son ☐ daughter
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: ____________________

I hereby authorize payment to be made directly tc McLaughlin Chiropractic Center for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to McLaughlin Chiropractic Center or any and all services I receive at this office.

______________________________ ______________
Patient or Authorized Person's Signature **Date Completed**

______________________________ ______________
Doctor's Signature **Date Form Reviewed**

Patient's Name: ____________________ **HR#:**______________ ___/___/___ **JDD, DC 9/2018**

Activities of Daily Living/Symptoms/Medications

Patient Name: ______________________________ **Date:** ____________ **File #:** ______________

Daily Activities: Effects of Current Conditions on Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activity				
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working Out	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Please mark P for in the Past or C for Currently.

___ Headache	___Blurred Vision	___Foot or Knee Problems	___Trouble Sleeping
___ Neck Pain	___Ringing in Ears	___Sinus/Drainage Problems	___Ulcers
___Jaw Pain/TMJ	___Hearing Loss	___Skin Problems	___Heartburn
___Shoulder Pain	___Depression	___Prostate Problems	___Heart Problem
___Upper Back Pain	___Irritable	___Impotence/Sexual Dysfun.	___High Blood Pressure
___Lower Back Pain	___Mood Changes	___Digestive Problems	___Low Blood Pressure
___Hip Pain	___ADD/ADHD	___Colon Trouble	___Asthma
___Back Curvature	___Allergies	___Diarrhea/Constipation	___Difficulty Breathing
___Scoliosis	___Pregnant (Now)	___Menopausal Problems	___Lung Problems
___Swollen/Painful joints	___Frequent Colds/Flu	___Menstrual Problems	___Kidney Trouble
___Dizziness	___Convulsions/Epilepsy	___PMS	___Gall Bladder Trouble
___Loss of Balance	___Tremors	___Bed Wetting	___Liver Trouble
___Fainting	___Chest Pain	___Learning Disability	___ Hepatitis (A,B,C)
___Double Vision	___Pain w/ Cough/Sneeze	___Eating Disorder	

___Numbness/Tingling in arms, hands, fingers

___Numbness/Tingling in legs, feet, toes

List any prescription drugs you take: ______________________________

____

List any non-prescription drugs you take: ______________________________

____

List any supplements you take: ______________________________

____

Initial Nerve System Profile

When was your most recent auto accident? ______________

Type of impact: Front Impact / Side Impact / Rear Impact

What speed was the collision? ______________

Did you receive treatment? Please describe: ______________________________

When was your most recent strain / stress at work? ____________

What type of injury: ______________________

Did you receive treatment? Please describe: ______________________________

Does your job require you to remain in long term stressful postures? ☐ Yes ☐ No

(i.e. all day sitting, repeated lifting, long term computer use)

Have you had any spinal traumas in the past? ☐ Yes ☐ No

Please circle all that apply below:

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field

Traumas as a child: fall on your head, impact to your head, concussion, falls onto your back or tailbone, biking accident

Work around the house: lifting, bending, woke up with stiff neck, "back went out"

Doctor Signature: ______________________________ Date: ______________ JDD, DC 9/2018

Office Policies

Welcome to McLaughlin Chiropractic Center

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read our office policies, if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your **application for care,** please let our front desk know and a member of our team will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors in our office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, as a patient at our office, you will gain a greater understanding as to the purpose of chiropractic. We offer multiple opportunities each month to better your understanding through weekly **Health Care Classes.** We HIGHLY recommend ALL our new patients, returning patients, and their families attend one of these classes. Chiropractic knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

- **Patient Privacy** – Since most of the patient care takes place in semi-private adjustment rooms, it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treatment hours when patients are being adjusted. If you have a confidential matter that you wish to discuss, please let us know and we will schedule time for you to speak with the doctor in a private consultation room. These consultations must be scheduled in advance.

- **Your Care** – When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at McLaughlin Chiropractic Center is rendered primarily to minimize and reduce subluxations, which are major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to, Thompson Drop, Diversified, Activator, Impulse Instrument, and Gonstead. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitation and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can! Our doctor will outline a course of treatment that will take you beyond simple pain relief, through distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, therefore improving your overall health.

- **First Things First** – Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while educating patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

- **Patient's Report of Findings** – To enhance your understanding of the chiropractic approach that will be used to manage your health, **BEFORE** your first adjustment, you will be scheduled for a "Report of Findings". The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your xrays and all examinations as well as the doctors' recommendations for care will be discussed during this time, we strongly urge all new and returning patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge receiving a copy of the practice's 'Office Policies'. Signing this document is evidence of my receiving and understanding the policies of our office. I further acknowledge that any concerns regarding there policies as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

______________________________ _______________

Patient's Name Date of Birth

______________________________ _______________

Patient's Signature (or guardian if applicable) Date

______________________________ _______________

Witness Date

McLaughlin Chiropractic Center NOTICE OF PRIVACY PRACTICES

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your personal health information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the last page and return only the signature page. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- semi-private adjusting means opportunity for open discussion. If you need to speak privately to the doctor please let our staff know so we can schedule you for a private consultation
3. For payment purposes- to obtain payment from your insurance company or any other collateral source
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For public health and safety- in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement- to identify or locate a suspect, fugitive, material witness, or missing person
8. For military, national security, prisoner, and government benefits purposes
9. Deceased persons- discussion with coroners and medical examiners in the event of a patient's death
10. Telephone calls, text messages, or emails and appointment reminders- **we may call, text, or email and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events**
11. Change of ownership- in the event this practice is sold, the new owners would have access to your personal health information

YOUR RIGHTS

1. To receive and accounting of disclosures
2. To receive a paper copy of this Notice of Privacy
3. To request mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with advance notice
6. To request amendments to information. However, like restrictions, we are not required to agree to them
7. To obtain **one** copy of your records at no charge, when timely notice is provided (72 hours).

NOTICE OF PRIVACY SIGNATURE PAGE

I have received a copy of McLaughlin Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of the "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

_______________________________   ____________________

Patient's Name   Date of Birth

_______________________________   ____________________

Patient's Signature (guardian if applicable)   Date

_______________________________   ____________________

Witness   Date

I give permission to Dr. Patrick McLaughlin and Dr. Nathan Swacha, associates, and the staff of McLaughlin Chiropractic Center to share private and medical information with the family members listed below.

Name	Relationship

Signature:______________________________________ Date: ____________________

McLaughlin Chiropractic Center

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care at this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to your prior to beginning your care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments as reported following my assessment.

______________________________ ____________________

Patient Name Date

____

Patient Signature (guardian if applicable)

______________________________ ____________________

Witness Signature (Staff) Date

McLAUGHLIN
CHIROPRACTIC

Informed Consent

McLaughlin Chiropractic Center requests at least 24 hours notice for appointment changes and cancellations. If you are unable to keep your appointment, please notify us by calling or texting our office and leaving a message or speaking with one of our team members.

We reserve the right to charge a $30 fee for missed appointments and late cancellations. We also have the right to charge a $50 fee for a no call no show appointment in which you do not attempt to contact us within 24 hours of your scheduled appointment. These fees will be paid out of pocket and cannot be billed to insurance. The patient will be responsible for payment of any and all late fees before more appointments may be scheduled.

During the course of my treatment at this practice, I consent to the knowledge of potential late fees and acknowledge that the doctor may dismiss me if care recommendations are not followed. If you miss multiple appointments with no justifiable cause, the doctor may dismiss your case.

______________________________ ____________

Patient Signature Date

______________________________ ____________

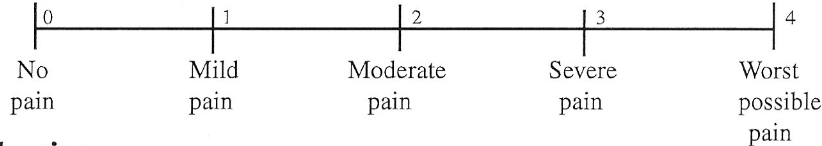
Witness Signature Date

Functional Rating Index

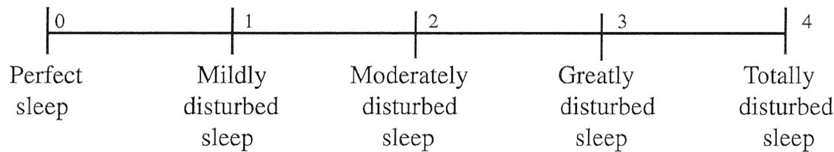
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

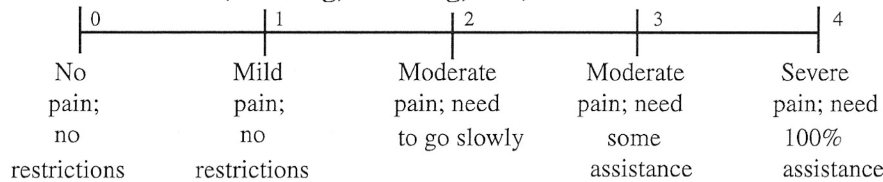
1. Pain Intensity



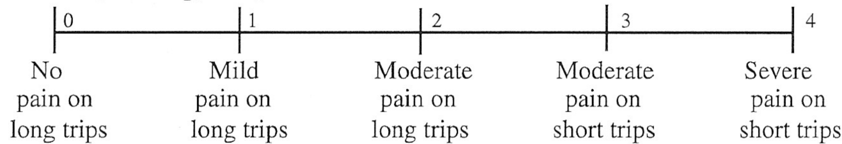
2. Sleeping



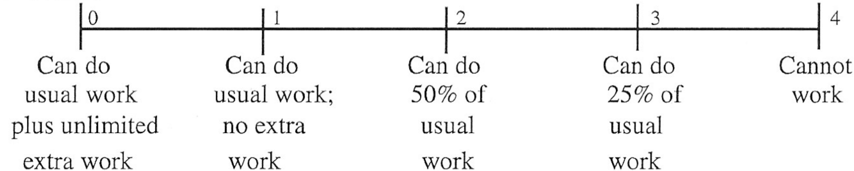
3. Personal Care (washing, dressing, etc.)



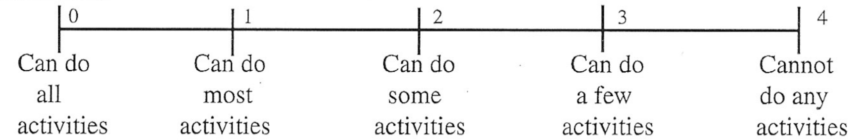
4. Travel (driving, etc.)



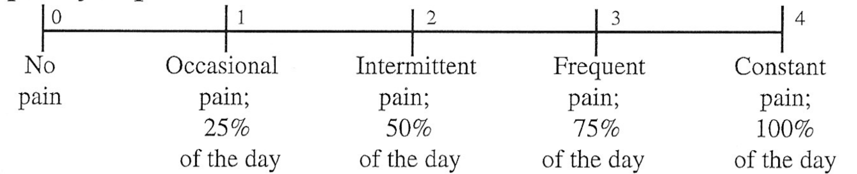
5. Work



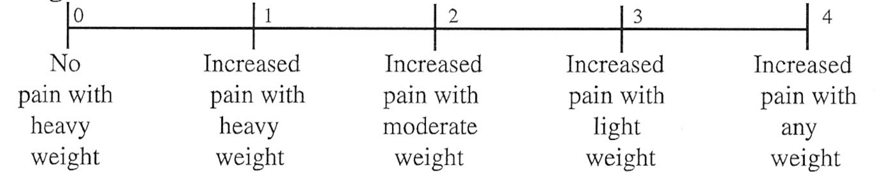
6. Recreation



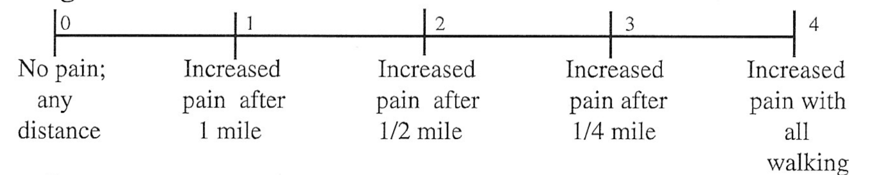
7. Frequency of pain



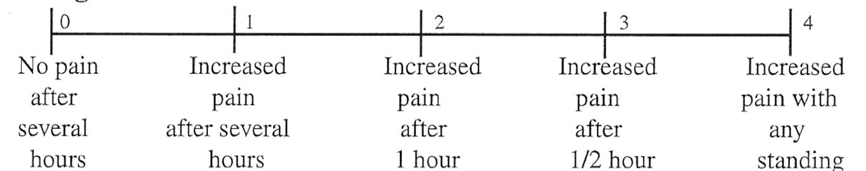
8. Lifting



9. Walking



10. Standing



Name ______________________________

PRINTED

____

Signature

____

Date

Total Score ____________

© Institute of Evidence-Based Chiropractic
www.chiroevidence.com