Confidential Health Information

Please allow us to photocopy your driver's license and insurance details.
All information you provide is confidential. We comply with all federal standards.

105 Fifth Street, Ste105
P.O. Box 388
Lynden, WA 98264
Phone (360) 318-0123
Fax (360) 318-0424

Today's Date: ___________________. Have you consulted a chiropractor before? ☐ No, ☐ Yes, When? _________, Whom? ______________
How were you referred to our office? ☐ Yellow Page, ☐ Internet, ☐ Insurance Directory, ☐ Physician, ☐ Other/Name ____________________

Contact Information

Last Name:	First Name:	Middle Name (or Initial):	
SS No:	Age:	Birthdate:	
Sex: ☐ Male, ☐ Female	Marital Status: ☐ Single, ☐ Married, ☐ Widowed, ☐ Divorced, ☐ Separated	Number of Children:	
Race:	Ethnicity:	Preferred Language:	
Spouse's Name:	Children (Name/Age):		
Home Address:	City:	State/Province:	Zip/Post Code:
Home Phone:	Cell Phone:	Email:	
Work Phone:	Preferred Method of Contact: ☐ Home, ☐ Cell Phone, ☐ Work Phone, ☐ Email		
Occupation:	Employer:		
Work Address:	City:	State/Province:	Zip/Post Code:
Emergency Contact:	Phone:	May we contact you at work? ☐ Yes, ☐ No	
Primary Care Provider:	City:	State/Province:	Last Seen:

Insurance Information

Primary Insurance Co:		Policy Number:	
Insured's Last Name:	First Name:	Insured's Date of Birth:	
Insured's Employer:		Who carries this policy? ☐ Self, ☐ Spouse, ☐ Parent	
Employer's Address:	City:	State/Province:	Zip/Post Code:
Secondary Insurance Co:		Policy Number:	
Insured's Last Name:	First Name:	Insured's Date of Birth:	
Insured's Employer:		Who carries this policy? ☐ Self, ☐ Spouse, ☐ Parent	
Employer's Address:	City:	State/Province:	Zip/Post Code:
Accident or Injury Claim: ☐ Work Injury, ☐ Vehicle Accident, ☐ Other ____________		Has injury or accident been reported? ☐ Yes, ☐ No	
Date of Occurrence:	Claim Number (if assigned):		
Insurance Company:	Does YOUR vehicle policy have Medical Payments coverage? ☐ Yes, ☐ No		
Insurance Address:		Insurance Phone:	
Attorney (if applicable):		Attorney Phone:	

Insurance Assignment, Authorization and Release

I, the undersigned, certify that I (or my dependent) have the insurance coverage indicated above. I hereby assign directly to Lynden Family Chiropractic, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. I authorize the use of this signature or its reproduction on all current and future insurance submissions.

✘ ____ ________________________________

Responsible Party Signature Date (MM/DD/YYYY)

PATIENT HISTORY

Patient Name ____ **Date** __________________

1. The **symptom(s)** that prompted you to seek care today include: ____

____

2. Are they the result of: ☐ Work Injury, ☐ Vehicle Accident, ☐ New Complaint, ☐ Worsening long-term problem, ☐ Other ___________

3. **Onset** (When did you first notice your current symptoms?) _________________________________ ☐ Sudden, ☐ Came on Gradually

4. If long-term problem, did something happen to worsen it? ____

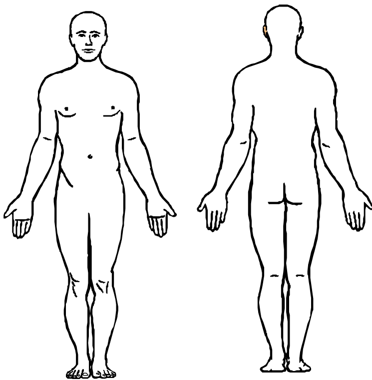
5. **Intensity** (Severity of symptoms?) ***Please Circle A Number*** : Absent 0 1 2 3 4 5 6 7 8 9 10 Agonizing

6. **Duration and Timing** (How often do you feel it?) ☐ Constant, ☐ Comes and goes. How Often? ______________________________

7. **Quality of Symptoms** (How does it feel? Check all that apply.) ☐ Dull/Aching, ☐ Sharp/Stabbing, ☐ Burning, ☐ Shooting, ☐ Throbbing ☐ Tightness/Stiffness, ☐ Spasm, ☐ Cramping, ☐ Numbness/Tingling, ☐ Swelling, ☐ Spasm, ☐ Other: _______________________

8. **Location** (Where does it hurt?)

   Please Circle the Area(s) on the Illustration below.



9. **Radiation** (Does it affect other areas of your body? To which areas does the pain radiate, shoot, or travel?)

   ____

10. **Aggravating or Relieving Factors** (What makes your pain better or worse, such as time of day, activities or movements?)

    What tends to worsen the problem?

    ____

    What tends to lessen the problem?

    ____

11. **Prior Interventions** (What have you done to relieve your symptoms?) ☐ Prescription Medication, ☐ Over-the-Counter Drugs, ☐ Surgery, ☐ Homeopathic Remedies, ☐ Acupuncture, ☐ Heat, ☐ Ice, ☐ Massage, ☐ Phys Therapy, ☐ Chiropractic, ☐ _____________

Activities of Daily Living

(How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Changing Positions	☐	☐	☐	☐
Standing or Walking	☐	☐	☐	☐
Bending or Stooping	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Getting out of Vehicle	☐	☐	☐	☐
Reaching Overhead	☐	☐	☐	☐
Turning Head	☐	☐	☐	☐
Lifting or Carrying Things	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery Shopping	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Carring for Family	☐	☐	☐	☐
Getting Dressed	☐	☐	☐	☐
Showering or Bathing	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Intimate Activities	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐

Review of Systems

(Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check the box in front on any condition that you've **Had** or currently **Have**.

a) Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Back Pain	☐	☐	Elbow/Wrist Pain	☐	☐	Foot/Ankle Pain	☐	☐	TMJ or Jaw Issues
☐	☐	Neck Pain	☐	☐	Hip Disorders	☐	☐	Arthritis	☐	☐	Scoliosis
☐	☐	Shoulder Problems	☐	☐	Knee Problems	☐	☐	Osteoporosis	☐	☐	Poor Posture

b) Neurological and Sensory

Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Headache	☐	☐	Pins and Needles	☐	☐	Recurring Ear Infection	☐	☐	Loss of Taste
☐	☐	Dizziness	☐	☐	Numbness	☐	☐	Hearing Loss	☐	☐	Anxiety
☐	☐	Blurred Vision	☐	☐	Ringing in Ears	☐	☐	Loss of Smell	☐	☐	Depression

c) Cardiovascular and Respiratory (☐ None; Initial _____________)

Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Easy Bruising	☐	☐	Sleep Apnea
☐	☐	Low Blood Pressure	☐	☐	Stroke or TIA	☐	☐	Poor Circulation	☐	☐	Emphysema
☐	☐	Chest Pain	☐	☐	High Cholesterol	☐	☐	Asthma or Hay Fever	☐	☐	Shortness of Breath

Consultation Notes

____
Doctor's Initials

(Continued from previous page) **Patient Name** ____ **Date** __________________

d) Gastrointestinal & Genitourinary (☐ None; Initial ____________)

Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anorexia/Bulimia	☐	☐	Ulcer	☐	☐	Kidney Stones	☐	☐	PMS Symptoms
☐	☐	Constipation	☐	☐	Heartburn	☐	☐	Frequent Urination	☐	☐	Infertility
☐	☐	Diarrhea	☐	☐	Food Sensitivities	☐	☐	Bedwetting	☐	☐	Prostate Issues

fe Endocrine & Constitutional (☐ None; Initial ____________)

Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Thyroid Issues	☐	☐	Immune Disorders	☐	☐	Hypoglycemia	☐	☐	Frequent Infection
☐	☐	Swollen Glands	☐	☐	Low Energy	☐	☐	Fainting	☐	☐	Low Libido
☐	☐	Poor Appetite	☐	☐	Fatigue	☐	☐	Sudden Weight Gain	☐	☐	Sudden Weight Loss

f) Skin (Integument) (☐ None; Initial ____________)

Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Skin Cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne
☐	☐	Hair Loss	☐	☐	Shingles	☐	☐	Rash			

Personal Health History

(Please identify your past health history, including accidents, injuries, illnesses and treatments.)

a) Illnesses

Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	AIDS (HIV Positive)	☐	☐	Epilepsy	☐	☐	Measles	☐	☐	Stroke
☐	☐	Alcoholism	☐	☐	Glaucoma	☐	☐	Multiple Sclerosis	☐	☐	Tuberculosis
☐	☐	Allergies	☐	☐	Goiter	☐	☐	Mumps	☐	☐	Typhoid Fever
☐	☐	Cancer	☐	☐	Gout	☐	☐	Polio	☐	☐	Ulcer
☐	☐	Chicken Pox	☐	☐	Hepatitis	☐	☐	Rheumatic Fever	☐	☐	Other______________
☐	☐	Diabetes	☐	☐	Malaria	☐	☐	Scarlet Fever	☐	☐	Other______________

b) Operations

☐	Appendix Removal	☐	Eye Surgery	☐	Elective Surgery ____
☐	Bypass Surgery	☐	Hysterectomy	☐	Spinal Surgery ____
☐	Cancer	☐	Pacemaker	☐	Other ____
☐	Cosmetic Surgery	☐	Tonsillectomy	☐	Other ____

c) Treatments and Medications

Past	Current		Past	Current		Past	Current	
☐	☐	Acupuncture	☐	☐	CPAP Machine	☐	☐	Hormone Replacement
☐	☐	Antibiotics	☐	☐	Chiropractic Care	☐	☐	Physical Therapy
☐	☐	Birth control pills	☐	☐	Dialysis	☐	☐	Medication ____________________________
☐	☐	Blood transfusions	☐	☐	Herbs	☐	☐	Medication ____________________________
☐	☐	Chemotherapy	☐	☐	Homeopathy/Supplements	☐	☐	Medication ____________________________

c) Past Injuries (Have you ever…?)

☐	Had a fractured or broken bone	☐	Been knocked unconscious	☐	Used a crutch or other support	☐	Received a tattoo
☐	Had a spine or nerve disorder	☐	Been injured in an accident	☐	Used neck or back bracing	☐	Had a body piercing

Family Health History

(Some health issues are hereditary. Please tell us about the health of your immediate family members.)

Relative	Age (if living)	State of Health		Illnesses	Age at Death	Cause of Death	
		Good	Poor			Natural	Illness
Mother	__________	☐	☐	____	__________	☐	☐
Father	__________	☐	☐	____	__________	☐	☐
Sister	__________	☐	☐	____	__________	☐	☐
Brother	__________	☐	☐	____	__________	☐	☐

Social History

(Please tell us about your health habits and stress levels.)

Alcohol Use	☐ Daily	☐ Weekly	How much? ______________	Pain Relievers	☐ Daily	☐ Weekly	How much? ________________		
Coffee Use	☐ Daily	☐ Weekly	How much? ______________	Water Intake	☐ Daily	☐ Weekly	How much? ________________		
Tobacco Use	☐ Daily	☐ Weekly	How much? ______________	Prayer/Meditation	☐ Yes	☐ No	Vaccinated?	☐ Yes	☐ No
Exercising	☐ Daly	☐ Weekly	How much? ______________	Job pressure	☐ Yes	☐ No	Recreational Drugs?	☐ Yes	☐ No

What is the major stressor in your life? ____

How much sleep do you average per night? __________ **hours. What is your preferred sleeping position?** ______________________________

Have you lost time from Work as a result of your current condition? ☐ **No,** ☐ **Yes: Dates:** ____

In addition to the main reason for your visit today, what additional Health Goals do you have? ____

Consultation Notes

____
Doctor's Initials

(Continued from previous page)

Terms of Acceptance

Chiropractic concerns itself primarily with the relationship of spinal structure and nerve function and the effect this relationship has on health. A disturbance of spinal alignment and function that results in altered nerve function is called vertebral subluxation. The goal of chiropractic is the elimination of vertebral subluxation and its interference with the body's ability to heal itself. This is accomplished primarily through the specific application of forces to the spine ("adjustments") to facilitate the body's correction of vertebral subluxation. The chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. Like the practice of all healing arts, chiropractic is not an exact science and no guarantee can be given as to the results or outcome of care.

Informed Consent

There are possible risks associated with techniques used by doctors of chiropractic. In particular you should note: a) While uncommon, some patients may experience short-term aggravation of symptoms, muscle and ligament injury, or rare fractures as a result of manual therapy procedures; b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Evidence does not establish a cause-and-effect relationship between chiropractic treatment and the occurrence of stroke, but rather suggests patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke already in progress. The possibility of injury occurring in association with upper cervical adjustment is extremely remote. However, you are being informed of this reported association because stroke may cause serious neurological impairment or even death; c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment; d) There are infrequent cases of burns or skin irritation associated with certain physiotherapy modalities offered by some doctors of chiropractic.

Initial — I acknowledge that I have read and understand the nature and purpose of chiropractic treatment in general and have been given the opportunity to discuss treatment options and recommendations for my condition as well as the potential risks of treatment or of failing to receive recommended treatment. My questions or concerns have been answered to my satisfaction prior to voluntarily signing this document. I hereby accept chiropractic care on this basis and give my consent to Dr. Lane Luxon to perform diagnostic tests and procedures as well as chiropractic treatment of my condition(s). I intend this consent to apply to both present and future chiropractic care.

Good Faith Estimate

Initial — Service fees vary according to provider contracts with insurance companies and the level and extent of service provided. At this time, Initial examinations range from $75 (minimal complexity/CPT 99201) to $390 (highly complex/CPT 99205); x-rays range from $45 to $115 per region visualized and may or may not be required depending upon the outcome of other testing; and recurring chiropractic treatment charges ranges from $45 (1-2 regions/CPT 98940) to $73 (over 4 regions/CPT 98943) with pre-paid discounts available. This Good Faith Estimate is only an estimate of items or services reasonably anticipated and is not a contract and does not require you to obtain the items or services from any provider or facility identified herein. Additional items or services may be required over the course of care and actual services or charges may be different. You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are $400 more than the expected charges included in the Good Faith Estimate and the dispute is initiated within 120 calendar days of the billing date. You may either ask us to update the bill to match the Good Faith Estimate; ask to negotiate the bill; or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services within 120 days of the date on the original bill. If the agency disagrees with you, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises. Your initials acknowledge you have been given an estimate of the costs associated with examination and treatment provided by this office.

Acknowledgements and Authorization

Initial — (Females Only) I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): ____________________.

Initial — I may request a copy of Lynden Family Chiropractic's Notice of Privacy Practices and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. I grant permission to be called to confirm or reschedule appointments and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.

Initial — I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non-covered services I receive. I understand that payment is due at the time of service unless otherwise arranged in advance.

Initial — To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern(s).

Dated this __________ day of __________________, 20________

☐ I conclude that the patient (or guardian) signing was of legal age and appeared to be unimpaired and oriented in person, place and time.

____	____
Patient Signature (Legal Guardian)	**Witness Signature**
____	____
Name (Please Print)	**Name (Please Print)**