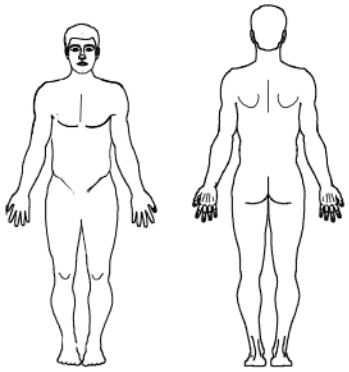
LIVE SMART
Chiropractic & Rehabilitation

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Gender: M / F
Address_____ City_____
State_____ Zip_____ Cell Phone (____)_____ Height_____ Weight _____
Occupation_____ E-Mail _____ Referred By:_____
Insurance Company_____
Subscriber Name_____
Subscriber ID #_____
Group #_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____
How Problem Began

Current complaint (how you feel today):
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?
No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

Continue on back

Doctor Use Only. Do not fill out this page.

LIVE SMART
Chiropractic & Rehabilitation

PHYSICAL EXAM/ORTHO/NEURO FORM

Patient Name:_____
Date:____/____/_____Dr. Trevor / Teresa Crossley, D.C.
1° Complaint:_____
2° Complaint:_____

EXAMINATION

VITALS:
Ht:_____ Wt:_____ BP: (L) ____/____ Temp:_____F°

Appearance	☐ Good ☐ Fair ☐ Poor
Cranial N.	- +I II III IV V VI VII VIII IX X XI XII
Posture:	**Rnd Shldrs** Y / N **Ant. Head Carriage**: Y / N **Antalgic Lean**: R / L **Elevated Shldr**: R / L
Feet/Knees:	Flat (↑)Supinated (↑)Pronated / (↑)Valgus (↑)Varus

PALPATION:

Joint Restrictions:	**C:** 0 1 2 3 4 5 6 7 **L:** 1 2 3 4 5 **T:** 1 2 3 4 5 6 7 8 9 10 11 12 **SIJ:** L R PI/AS **Sac:** R L **Base Post.** **Extremity:** Shldr Elb Wrist Hip Ank
Hypertonic Muscles	

ACTIVE ROM:

Cervical ROM	L	R	Comments
Flexion (60°)			
Extension (75°)			
Lat Flexion (45°)			
Rotation (80°)			

P = Pain B = Bilateral T = Tight (↓) = Decreased (↑) = Increased

Lumbosacral ROM	L	R	Comments
Flexion (60°)			
Extension (25°)			
Lat Flexion (25°)			
Rotation (20°)			

NEURO EXAM	DTR'S			MYOTOMES			SENSORY		
	L	N	R	L	N	R	L	N	R
C5/deltoid		+2			+5B			NB	
C6/biceps		+2			+5B			NB	
C7/triceps		+2			+5B			NB	
C8/interossei					+5B			NB	
T1/interossei					+5B			NB	
L4/quad/dflx		+2			+5B			NB	
L5/ hams/toe		+2			+5B			NB	
S1/toe flx/ex		+2			+5B			NB	

Clonus-Wrist/Foot) (-) (+) Hoffman's (-) (+) Babinski (-) (+)
NB = Normal Bilateral B = Bilateral (↓) = Decreased (↑) = Increased

ORTHOPEDIC EXAMS:

Cervical Exam	LEFT		RIGHT		Comments
Comp Neutral	(-)	(+)	(-)	(+)	
Comp Flexion	(-)	(+)	(-)	(+)	
Comp Extension	(-)	(+)	(-)	(+)	
Comp Rotation	(-)	(+)	(-)	(+)	
Comp Lat Flex	(-)	(+)	(-)	(+)	
Distraction	(-)	(+)	(-)	(+)	
Shoulder Depress	(-)	(+)	(-)	(+)	
Max Foraminal	(-)	(+)	(-)	(+)	

P = Pain B = Bilateral T = Tight (↓) = Decreased (↑) = Increased

Lumbar Exam	LEFT		RIGHT		Comments
Kemps	(-)	(+)	(-)	(+)	
Bechterew	(-)	(+)	(-)	(+)	
Valsalva		(-)	(+)		
Slump	(-)	(+)	(-)	(+)	
SLR	(-)	(+)	(-)	(+)	
Bragard's	(-)	(+)	(-)	(+)	
Patrick/FABER	(-)	(+)	(-)	(+)	
Nachlas	(-)	(+)	(-)	(+)	
Ely's	(-)	(+)	(-)	(+)	
Yoeman's	(-)	(+)	(-)	(+)	
SIJ Compres	(-)	(+)	(-)	(+)	
Sacral Compress	(-)	(+)	(-)	(+)	
Toe Walk	(-)	(+)	(-)	(+)	
Heel Walk	(-)	(+)	(-)	(+)	
Stork Test	(-)	(+)	(-)	(+)	
	(-)	(+)	(-)	(+)	

Add Ortho Tests	LEFT		RIGHT		Comments
FADDIR	(-)	(+)	(-)	(+)	
Empty Can	(-)	(+)	(-)	(+)	
Hawkin's Kennedy	(-)	(+)	(-)	(+)	
Shldr Apprehension	(-)	(+)	(-)	(+)	
ULTT	(-)	(+)	(-)	(+)	
	(-)	(+)	(-)	(+)	
	(-)	(+)	(-)	(+)	
	(-)	(+)	(-)	(+)	
	(-)	(+)	(-)	(+)	
	(-)	(+)	(-)	(+)	
Ortho Test Comments					

DIAGNOSIS:

RECOMMENDATIONS:

Activity Mod	Rest	Ice/Heat	Rehab

Comments:

Dr. Signature: _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands, mechanical device, or gentle non-force techniques in order to perform chiropractic adjustments & treatment that involves moving your joints, muscles, and other soft tissues. You may feel & hear an audible "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. This mechanism is known as tribonucleation and is a very safe treatment. Bones are not popping or cracking during an adjustment. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry manual therapy may also be used.

Possible Risks: As with any health care procedure, complications are possible, although very rare, following a chiropractic manipulation. Complications could include muscle soreness, fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke is extremely rare, but could occur upon treatment just as with other professional treatments. Severe injuries to arteries of the neck are possible, but exceedingly rare. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. These should dissipate within those few days.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options, which could be considered, may include the following:*Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases. *Medical care,* typically anti-inflammatory drugs, steroid injections, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation longer and more difficult.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise proper judgment during the course of the procedure(s) by which the doctor feels at that time, based on the facts then known, are in my best interest. I understand that results are not guaranteed. 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 cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have read the explanation above of chiropractic treatment and the associated risks. I have fully evaluated the risks and benefits of undergoing treatment. I hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy (or on the patient named below, for whom I am legally responsible for) by the doctor or intern, affiliated with LiveSmart Chiropractic & Rehabilitation. I have read, or have had this read to me, the above consent. By signing below, I agree to the above and allow the doctor or intern, affiliated with LiveSmart Chiropractic & Rehabilitation to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition and for any future condition(s) for which I seek treatment. I have freely decided to undergo chiropractic care and herby give my full consent to treatment.

Consent to Treat a Minor (17 years & Under): If you are 17 years of age or younger, your parent or guardian must be present to sign this form and provide consent. Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _____ as the examining/treating doctor deems necessary. As the parent or legal guardian of this patient, please print the child's name below and sign with your signature at the bottom of this page.

Patient Name (Print)_____**Date**_____

Patient Signature_____

Continue on next page

NOTICE OF PRIVACY PRACTICES

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. LiveSmart Chiropractic & Rehabilitation is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. **HIPAA** - Authorization to Release Medical Information **-** I authorize the release of any medical information necessary to process my insurance claims and also certify that all insurance information to this clinic is correct and complete. **Patient Record of Disclosures -** In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We may discuss your health information with medical doctors, legal representation, insurance companies, and your spouse or children. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we would be happy to send you more information at your request. If there is anyone you do not want us to discuss your medical information with or to receive your medical records, please inform our office. Otherwise, you agree to and authorize us fully to provide medical information to the above mentioned parties if we choose to do so. You understand we may contact you via phone call, text message, e-mail, or by mail at your current address on file. I understand it is my responsibility to inform you of any contact methods I do not wish to receive

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

Treatment - We may disclose your health care information with other healthcare professionals for the purpose of treatment, payment or healthcare operations.

Payment - If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. Your file, containing protected health care information, may be reviewed by the designated collection agency or authority.

Workers' Compensation - If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws. **Emergencies** - We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health -As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Judicial and Administrative Proceedings -We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement - We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes. **Deceased Persons -** We may disclose your health information to coroners or medical examiners.

Public Safety - It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Marketing, Social Media, and Other Communications- - We may use social media to post pictures/video of you/your treatment. We may also contact you to inform you of upcoming/missed appointments, as described: (example) - "As a courtesy to our patients, it is our policy to call your home on the evening prior to your appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on you answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment.

Specialized Government Agencies - We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership - In the event that LiveSmart Chiropractic & Rehabilitation is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights - You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that LiveSmart Chiropractic & Rehabilitation is not required to agree to the restriction that you requested. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. You have the right to inspect and copy your health information. You have a right to request that LiveSmart Chiropractic & Rehabilitation amend your protected health information. Please be advised, however, that LiveSmart Chiropractic & Rehabilitation is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason (s) and information about how you can disagree with the denial. You have a right to receive an accounting of disclosures of your protected health information made by LiveSmart Chiropractic & Rehabilitation. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices - LiveSmart Chiropractic & Rehabilitation reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, LiveSmart Chiropractic & Rehabilitation is required by law to comply with this Notice. LiveSmart Chiropractic & Rehabilitation is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: LiveSmart Chiropractic & Rehabilitation by calling this office at (858) 634 -2225. If LiveSmart Chiropractic & Rehabilitation is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

I have read the Privacy Notice and understand my right contained in the notice. By way of my signature, I provide LiveSmart Chiropractic & Rehabilitation with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient Name (Print) _____**Date**_____

Patient Signature_____

Continue on back

Financial Policy

Payment for treatment: - You agree to pay by cash ,check ,or credit card on the day that treatment is rendered. Unless we approve other arrangements in writing, the balance on your account is due and payable when the services are rendered, and is past due if not paid by this time.

Insurance: If applicable, I hereby authorize my health insurance company or claims administrator (personal injury/car accident) to pay by check, and for it to be made directly to LiveSmart Chiropractic & Rehabilitation the expenses benefits allowable and otherwise payable to me under my current policy as payment toward the total charges or professional services rendered. I have agreed to pay in a current manner, any balance of said applicable charges. I agree that this office by given power of attorney to endorse/sign my name on any and all drafts for payment of my bill. Full payment is expected at the time of service unless prior arrangements have been made. It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payors. All insurance assignment patients must pay their deductibles in full and the co-payment at the time of service, or at the end of each week.

Missed Appointment Fees: Patients who do not show up for an appointment or cancel with less than 24 hours notice will be charged a **the total cost of the visit unless otherwise stated by the provider** . This fee must be paid before a new appointment is scheduled, and will be charged to the patient's payment account on file. Providing updates to any and all contact information are the sole responsibility of the patient.

Credit History: We may report your account status to any credit-reporting agency such as a credit bureau for delinquent accounts. If your accounts become past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all court costs.

Returned Checks: There is a fee (currently $25) for any checks returned by the bank.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You understand that you will need to request in writing, and pay a reasonable copying fee (currently $25) if you want to have a printed copy of your patient health record.

I certify to the best of my knowledge, the above information is complete and accurate. If using a health insurance plan and the information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service." Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures authorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies. Although rare, insurance companies may provide us with incorrect information about your health plan. Thus, I understand that it is ultimately my responsibility to verify my chiropractic insurance benefits.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name (Print)_____ Date_____

Patient Signature _____