Danville Area
CHIROPRACTIC CENTER
DR. TERRY LAUBACH DC

Confidential Patient Information Acct # _____

(Please Print)

Date: _____

Full Name: _____

Birthdate: _____ Age: _____

Email Address: _____

Address: _____

City: _____State: _____ Zip Code: _____

Telephone Number: (_____)_____ Cell Phone: (_____)_____

Primary Care Physician Name:_____

Occupation:_____

Employer's Name: _____ Employer's Phone Number: _____

Student: No Full Time Part Time

Are you Pregnant? **YES NO** If pregnant when is your due date? _____

Marital Status: S M D W

Name of Wife, Husband or Guardian: _____

Name and Phone # of Emergency Contact: _____

How did you hear about our office?_____

List of Chiropractors you have seen before:

1. Name: _____ Last appointment date: _____
2. Name: _____ Last appointment date: _____
3. Name: _____ Last appointment date: _____

Please list all of your reasons for visiting our office:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List **All** previous hospitalizations, surgeries, accidents, fractures and illnesses. (Example: **All past** Auto, Sports, Work, Home related)

1. Type _____ When _____ Hospitalized? Yes No
2. Type _____ When _____ Hospitalized? Yes No
3. Type _____ When _____ Hospitalized? Yes No
4. Type _____ When _____ Hospitalized? Yes No
5. Type _____ When _____ Hospitalized? Yes No
6. Type _____ When _____ Hospitalized? Yes No

Do you currently see or have been seen by **pain management**? YES NO

What kind of treatment did they perform and in what area of the body? (example: **pain medication injection, oral medications, etc.**)

_____

Facility and Physician name that administers your treatments:_____

When was your last injection? _____How long have you been receiving injections? _____

List **All** medications you take. (Prescriptions and over-the-counter)

Drug Name:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

List **ALL** nutritional supplements you take.

Name of Supplements:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check **ALL** "body signals" (symptom's/pain) you may have had or do have now:

___ ADD/ADHD	___ **Cancer**	___ Epilepsy/seizures	___ **Implanted devices**	___**Pacemaker**
___ Alcoholism	___ Celiac/Gluten Dis	___**Falls**	___ Irregular Periods	___ Parkinson's disease
___ Allergy	___ **Chronic Fatigue**	___ Fibromyalgia	___ Irritable Bowel	___ Pneumonia
___ Alzheimer's	___ Constipation	___ Gall Bladder Dis	___ **Kidney Disease**	___ Raynaud's
___ Anemia	___ Crohn's Dis/UC	___ Goiter	___ Kidney Infections	___ Rheumatoid Arthritis
___**Aneurysm**	___ Depression	___ Gout	___ **Kidney Stones**	___ Ringing in the Ears
___ Appendicitis	___ **Diabetes**	___ **Headaches/Migraines**	___ Low Blood Pressure	___Scoliosis
___ Asthma	___ Dialysis	___ Heart Attack	___ Low Blood Sugar	___**Spinal implants/cage**
___ **Arthritis**	___Diarrhea	___ Heart Disease/Failure	___ **Lymes Disease**	___Sinus Infection
___Atrial Fib/Irregular HR	___ Eczema	___ Hepatitis	___ Lupus	___ **Stroke**
___ Autoimmune Dis	___ Esophageal Varices	___ **High Blood Pressure**	___ Miscarriage	___ Thyroid Disease
___ Back Pain	___Excessive Gas/Burping	___ **High Cholesterol**	___ Multiple Sclerosis	___ Ulcers
___ Balance Issues	___ Emphysema	___ HIV/AIDS	___Memory problems	___ **Vertigo**

Please Check **ALL** the following conditions your family has experienced.

Mother:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Father:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Grandmother (M):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Grandfather (M):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Grandmother (P):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Grandfather (P):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Sisters:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Brothers:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	

List any other health conditions that you or your family have had that are not listed above:

_____

Do you consume any of the following?

Tobacco products (pack/day) _____ How many years? _____ Alcohol drinks/day _____ How many years? _____

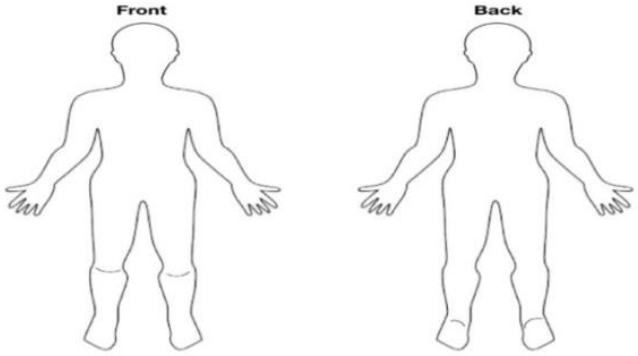
Coffee/Tea (cups/day) _____ **Regular Decaf** Soda Drinks (cans/day) _____ **Regular Diet**

Do you use artificial sweeteners? **Yes No** If yes please list which kinds? _____

Level of exercise: **None Moderate Strenuous** How many days per week? _____ Have you experienced unexplained or rapid weight changes in the last six months? **Yes No** If yes, how many pounds? _____LBS

Was this intentional? **Yes No**

Please mark off the areas of your complaint on the diagram below. Use the following symbols: **P- Pain, N- Numbness, T- Tingling, B = Burning, C = Cramping**



Informed Consent for Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.**

One disturbance to the nervous system is called a **vertebral subluxation/ neuropsychological dysfunction/ somatic dysfunction**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Vertebral subluxation/ neuropsychological dysfunction/ somatic dysfunction corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation/ neuropsychological/ somatic dysfunction under the scope of practice for chiropractic care in the state of Pennsylvania. However, if during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

Name(s) of Emergency Contacts and medical record obtainability:

_____

_____

_____

_____

PLEASE CONTINUE TO NEXT PAGE

Privacy Authorization for Care

Dr. Terry Laubach DC and members of the practice staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member with your written consent.

You can restrict the individuals to which your health care information is released, or you may revoke your authorization to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in a small building with an open room style, with other patients in the same room or next room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits. This may be overheard by other patients, staff members and guests. You are also bound in this agreement by HIPPA that if you overhear other patient's medical information you are bound by law to keep this information private. Failure to do so may result in legal ramifications by our office or the patient.

You may inspect or request a copy, for a fee, the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time.
This authorization will expire seven years after the date in which you last received services from us. You may receive a copy of this form when needed.

I hereby give permission to Danville Area Chiropractic Center to release any and all medical and/or billing information that I have received while being a patient here at this facility to the necessary person or persons (family members, legal guardian, next of kin, Physicians etc.)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

I acknowledge that I have received Danville Area Chiropractic Center's notice of Privacy Practices. I authorize you to use or disclose my health information in the manner described.

Patient's Name:_____

Patient's Signature: _____**Date:**_____

Minors Only:

I, _____being the parent or legal guardian of _____
Have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Signature: _____ Date: _____