LYNDEN FAMILY CHIROPRACTIC, LLC
HEALTH & WELLNESS CENTER

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):
Social Security No:	Age:	Birthdate:
Gender: ☐ 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:	SS No:
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

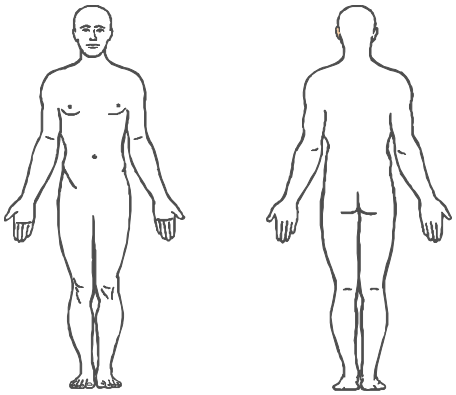
Patient Name _____ **Date** _____

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** (How extreme are your current 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.) ☐ Numbness, ☐ Tingling, ☐ Stiffness, ☐ Dull, ☐ Aching, ☐ Cramping, ☐ Nagging, ☐ Sharp, ☐ Burning, ☐ Shooting, ☐ Throbbing, ☐ Stabbing, ☐ 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, ☐ _____

12. **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	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in and out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐

13. **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**. If "None", please initial to the right of your selection.)

a) Musculoskeletal ☐ None; Initial _____

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

b) Neurological/Sensory ☐ None; Initial _____

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

c) Cardiovascular ☐ None; Initial _____

Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	High Blood Pressure	☐	☐	Chest Pain	☐	☐	High Cholesterol	☐	☐	Poor Circulation
☐	☐	Low Blood Pressure	☐	☐	Heart Disease	☐	☐	Stroke or TIA	☐	☐	Excessive Bruising

Consultation Notes

_____
Doctor's Initials

d) Respiratory ☐ None; Initial _____

Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Asthma or Hay Fever	☐	☐	Apnea	☐	☐	Emphysema	☐	☐	Shortness of Breath

e) 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

f) 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

g) Skin (Integument) ☐ None; Initial _____

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

14. 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	☐	☐	Epilepsy	☐	☐	Malaria	☐	☐	Sexually Trans Disease
☐	☐	Alcoholism	☐	☐	Glaucoma	☐	☐	Measles	☐	☐	Stroke
☐	☐	Allergies	☐	☐	Goiter	☐	☐	Multiple Sclerosis	☐	☐	Tuberculosis
☐	☐	Arteriosclerosis	☐	☐	Gout	☐	☐	Mumps	☐	☐	Typhoid Fever
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	Polio	☐	☐	Ulcer
☐	☐	Chicken Pox	☐	☐	Hepatitis	☐	☐	Rheumatic Fever	☐	☐	Other _____
☐	☐	Diabetes	☐	☐	HIV Positive	☐	☐	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 _____

d) 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

15. Family Health History (Some health issues are hereditary. Please tell Dr. Luxon 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 1	_____	☐	☐	_____	_____	☐	☐
Sister 2	_____	☐	☐	_____	_____	☐	☐
Brother 1	_____	☐	☐	_____	_____	☐	☐
Brother 2	_____	☐	☐	_____	_____	☐	☐

16. Social History (Please tell Dr. Luxon 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

Consultation Notes

_____
Doctor's Initials

17. What is the major stressor in your life? _____

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

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

20. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

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 manual therapy techniques used by doctors of chiropractic. In particular you should note: a) While rare, some patients may experience short-term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rare fractures have been known to occur following certain manual therapy procedures; b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific 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 that is already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of injuries occurring in association with upper cervical adjustment is extremely remote; 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 have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the potential risks of treatment or of failing to receive recommended treatment. I have had any questions or concerns 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 all my present and future chiropractic care.

Acknowledgements and Authorization

Initial — 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)

Consultation Notes

_____
Doctor's Initials