Livingston Chiropractic

Dr. Stuart Meyers, D.C.
5889 Whitmore Lake Rd #3, Brighton, MI 48116 ❊ 810-227-7799 ❊ www.LivChiro.com

Name: _____

Care Application

Date: _____

Nickname: _____ Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone #: _____ Alternate Phone #: _____

Email Address: _____

Occupation (Current or Previous): _____ Retired: ☐ Yes ☐ No

Employer: _____

Current or Previous Work Type:

Clerical – Y / N Light Labor – Y / N Moderate Labor – Y / N Heavy Labor – Y / N

Name of Spouse/Partner/Parent or Other Trusted Adult: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W Number of Children: _____

In Case of Emergency: Contact Name: _____ Phone #: _____

How did you hear about our office? ☐ Advertisement ☐ Website ☐ Insurance ☐ Social Media

☐ Friend _____ ☐ Doctor _____ ☐ Other _____
Name Name

☐ I do not have/wish to use insurance for my care. ☐ I would like to use insurance.

Is your condition directly related to an auto accident? ☐ Yes ☐ No On-the-job injury? ☐ Yes ☐ No

Policy Holder's Name _____ Birth Date ____/____/_____

Policy Holder's Address _____ City _____ State _____ Zip _____

What is your main health concern / condition coming in today? _____

When did this begin? _____

What makes it worse? _____

What makes it better? _____

How would you describe your symptoms? *(Circle any that apply)*

☐ Limping	☐ Stiff	☐ Swelling	☐ Stabbing	☐ Sharp	☐ Grinding
☐ Throbbing	☐ Ache	☐ Weakness	☐ Tiredness	☐ Electric Shocks	☐ Cold
☐ Burning	☐ Numbness	☐ Cramping	☐ Dead Feeling	☐ Stings	☐ Pins & Needles

Is this condition interfering with any of the following? *(Circle any that apply)*

☐ Daily Activities ☐ Relationships ☐ Hobbies ☐ Exercise ☐ Standing ☐ Walking ☐ Lifting ☐ Sleep ☐ Work

Frequency of your Pain:

☐ Constant (76–100%) ☐ Frequent (51–75%) ☐ Occasional (25–50%) ☐ Intermittent (24% or less)

On average what level would you rate your overall pain?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

On a scale of 0 – 10, How serious and committed are you about fixing your condition?

Not Serious 1 2 3 4 5 6 7 8 9 10 Totally Committed

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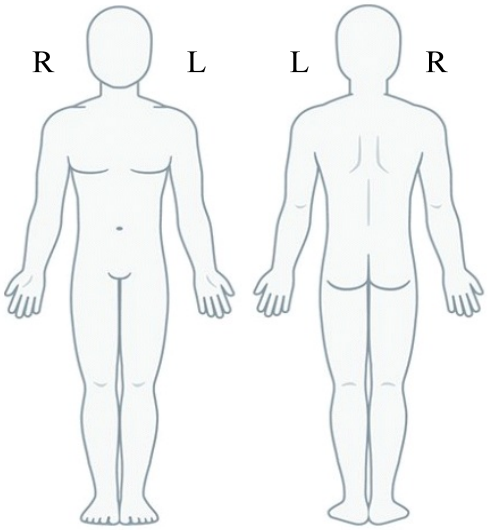
Please shade the area(s) where you are currently experiencing symptoms:



Has your pain interfered with daily activities (walking, going up/down stairs, prolonged standing, sit to stand) for at least 6 months? _____

Have you tried pain and / or anti-inflammatory medications (i.e. Tylenol, Aspirin, Aleve, Advil, Prescription Medications, Pain Creams, etc.) for at least 3 months without gaining long term relief from your symptoms? If yes, what have you tried?

_____

Have you tried physical therapy without long-term relief from your symptoms?

_____

What activities is your pain preventing you from doing?

_____

Have you tried Steroid / Cortisone Injection(s) without long-term relief?

☐ No ☐ Yes - How many? _____

Please list any / all prescription medications or vitamins / supplements you are currently taking (or you may attach a list):

Name of Prescription Medications / Vitamins / Supplements	**What are they for?**

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Name: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____
Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many cigarettes daily? _____
Do you exercise regularly? ☐ Yes ☐ No If yes, please describe type & how often? _____

Please list below any Back or Leg, etc surgeries you've had and the dates: _____

Have you had an MRI performed? ☐ No ☐ Yes, When? _____ Where? _____

COMPREHENSIVE HEALTH HISTORY

☐ Neck Pain	☐ Headaches	☐ Heartburn	☐ Diabetes - Type I or II
☐ Low Back Pain	☐ Spinal Arthritis	☐ Heart Attack	☐ TMJ
☐ Herniated/Bulging Disc	☐ Spinal Surgery(s)	☐ Stroke	☐ Carpal Tunnel Syndrome
☐ Sciatica	☐ Joint Replacement	☐ High Blood Pressure	☐ Shoulder Pain
☐ Leg or Foot Pain / Numbness	☐ Knee Surgery(s)	☐ High Cholesterol	☐ Leg Fracture
☐ Hand Pain/Numbness	☐ Foot Surgery(s)	☐ Cancer	☐ Vascular Leg Problems
☐ Neuropathy	☐ Other:		

Name of your Primary Care Physician: _____
Office / Clinic: _____
May we contact them with updates regarding your treatment? ☐ No ☐ Yes: _____
(Phone Number)

I hereby authorize the release of any medical information necessary to evaluate my case to:
_____.

Livingston Chiropractic will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patient's responsibility to contact their own insurance provider.

We invite you to discuss with us any questions regarding our services and/or fees. The best health services are based on a friendly, mutual understanding between the provider and patient. I understand the above information, and agree this form was completed correctly, to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

Signature: _____ **Date:** _____

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Pain Questionnaire

These questions ask about limitations you may be experiencing due to your pain during the last 10 days.
For each question, please circle only **ONE** answer that best describes your degree of limitation.

Date: _____

In the past 10 days, how has your pain affected….	**NOT AT ALL** **Able to Complete**	**A LITTLE** **Still Able to Complete**	**QUITE A BIT** **Unable to Complete Some Days**	**MODERATELY** **Unable to Complete Most Days**	**EXTREMELY** **Unable to Complete Task**
Your ability to walk without assistance (cane or walker)?					
Your ability to walk without a limp?					
The distance you are able to walk?					
Your ability to use stairs? (up or down)					
Your ability to fall asleep or stay asleep through the night?					
Your balance or stability when walking or standing? (falling or unsure footing)					
Your ability to get up from a seated position?					
Your ability to complete daily activities around your home? (Laundry, dishes, vacuuming, cooking, etc.)					
Your ability to complete errands? (Grocery shopping, doctors' appointments, etc.)					
Your ability to care for yourself? (Bathe, get dressed, etc.)					
Your ability to get in and out of a vehicle?					

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Functional Goals Survey

Please answer these questions the best you can so we can help you get better.

Date: _____

1. What is the ***main reason*** you have come to see us today? _____
   _____
2. How many doctors have you seen for this condition? _____
3. What medications/supplements/therapies/treatments did they prescribe/recommend for you?
   _____
   _____
4. Has what you've done to date for your condition helped?
   ☐ Yes, a lot ☐ Yes, some ☐ No, not at all ☐ Indifferent
5. What are 3 - 5 activities you can no longer do or are struggling to do because of this condition? Please be specific.
   1. _____
   2. _____
   3. _____
   4. _____
   5. _____
6. What is your honest vision of your life in the next few years if this problem continues to progress?
   _____
   _____
7. What would be different and/or better without this problem? Please be specific.
   _____
   _____
   _____
8. What is your biggest fear in regards to the progression of this condition?
   _____
   _____
   _____
9. What would be and/or mean success to you in our office?
   _____
   _____
   _____

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CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Stuart Meyers, D.C. and/or other licensed doctors of chiropractic who now or in the future work at Livingston Chiropractic.

I have had an opportunity to discuss with Dr. Meyers and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then know, is in my best interest.

To the best of my knowledge I am ***NOT*** pregnant and Dr. Meyers has my permission to x-ray me for diagnostic interpretation.

I understand that there is no implied cure or guarantee of improvement by my agreeing to the Doctor's recommendations. I further understand that my failure to comply fully with these recommendations will limit my results from the treatment received. I also acknowledge that I am responsible for services and/or products that are rendered.

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 treatment and x-rays. 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.

By signing this authorization, I am also agreeing to have texts and/or emails sent to the number or email I have provided, from Livingston Chiropractic and its employees.

_____ _____

Patient's Signature or of person acting on patient's behalf **Date**

_____ _____

Witness's Signature **Date**

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PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA)

I understand that Livingston Chiropractic's "Notice of Privacy Practices" in its full form is available to me upon request and that I have a right to review the "Notice of Privacy Practices" prior to signing this document.

The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information and the policies and procedures of confidentiality that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Livingston Chiropractic. This "Notice of Privacy Practices" also describes my rights and Livingston Chiropractic's duties with respect to my protected health information and patient confidentiality.

Livingston Chiropractic reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices." I may obtain a copy of the revised notice by calling the office and requesting a copy be sent to me by mail or by asking for one at the time of my next appointment.

I give permission for the doctor(s) and/or staff to discuss my

☐ Care / Condition / Treatment ☐ Financial Statements with the following persons.

Name	**Relationship**
_____	_____
_____	_____

☐ I do not wish any of my information discussed with anyone but myself.

I understand the above permissions will remain in effect until such time as they are revoked in writing. A new authorization, when completed, will replace any older authorizations.

_____ _____

Patient's Signature or
Signature of person acting on patient's behalf (relationship)

Date

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OFFICE FINANCIAL POLICY

We welcome you and your family to our office. We take pride in providing quality chiropractic care for families. Please take time to review our Office Financial Policy, as these guidelines have been designed to better serve your individual needs.

PAYMENT POLICY

Payment is due the day service is provided.

- Our doctor is not in any insurance networks. There may be out-of-network coverage through your policy. Our staff will be happy to check with your insurance company to check out of network coverage but this is not a guarantee of coverage.

- Please communicate with the receptionist whether you will be filing claims to an insurance company and present your current insurance card to the receptionist for her to make a copy. If at any time you change insurance companies, please notify the receptionist immediately to update your records. All insurance claims are filed weekly on Thursday or Friday.

- We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to directly assist your insurance company, adjustor or agent. Any denied or disputed claims will be treated as uncovered services.

- If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, payment in full is due; regardless of any claims submitted.

MY FINANCIAL RESPONSIBILITY

I understand that I am personally **financially responsible** for all services not covered by Insurance or by Medicare. I am also responsible for all applicable annual deductibles or copayments.

CANCELLATION POLICY

If for any reason you cannot make your pre-scheduled appointment time we do ask for a 24-hour notice. If we do not hear from you to cancel your appointment at all or at least one hour before your pre-scheduled appointment more than three times an administrative fee of $25.00 will be charged to your account. No further treatments will be administered until this fee is paid.

We thank you for your understanding.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's Signature or person acting on patient's behalf **Date**