

# Lake Wylie Family Chiropractic, Inc.

## Doc Marcia, LLC.

**Welcome to our office! Please complete each page to the best of your ability.**  
**Please ask if you need any help.**

**ABOUT YOU**

*(Some of the information requested here we are required by law to collect as a primary care facility. It has no relevance to the care you will receive at this office)*

**Today's Date:** \_\_\_/\_\_\_/\_\_\_ **Whom may we thank for your referral?** \_\_\_\_\_

**Patient Title:**     Mr.     Mrs.     Ms.     Miss     Dr.     Prof.     Rev.

**First Name** \_\_\_\_\_ **Nick Name** \_\_\_\_\_

**Last Name** \_\_\_\_\_ **Middle Name** \_\_\_\_\_ **Suffix** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Primary Phone** \_\_\_\_\_ **Secondary Phone** \_\_\_\_\_

**Home e-Mail:** \_\_\_\_\_ **Work e-Mail:** \_\_\_\_\_

**Which email address shall we communicate with you?** *(check one)*     Home     Work

**Preferred Contact Method** *(check one)*

Primary Phone     Secondary Phone     Home Email     Work Email

**Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Age** \_\_\_\_\_ **Gender:**  Male     Female     Unspecified

**Marital Status**     Single     Married     Other    **SSN:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Employment Status:**

Employed     F/T Student     F/T Student     Retired     Other

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Race** *(check one)*

White     Black/African American     Hispanic     American Indian/Alaskan Native  
 Asian     Asian Indian     Chinese     Filipino  
 Japanese     Korean     Vietnamese     Hawaiian or Pacific Islander  
 Samoan     Guamanian/Chamorro     Other \_\_\_\_\_  I choose not to specify

**Multi-Racial** *(check one)*     Yes     No     Unknown

**Ethnicity:**     Hispanic/Latino     Not Hispanic/Latino     I choose not to specify

**Preferred Language** *(check one)*

English     Spanish     American Sign Language     Chinese     French     German  
 Tagalog     Vietnamese     Italian     Korean     Russian     Polish  
 Arabic     Portuguese     Japanese     French Creole     Greek     Hindi  
 Persian     Urdu     Gujarati     Armenian     I choose not to specify

**Verification Question** *(Please choose a question that we can use to verify your identity when we communicate with you and give the answer to that question in the space provided)*

What's the name of your favorite pet?     In what city were you born?     What high school did you attend?  
 What is your favorite movie?     What is your mother's maiden name?     On what street did you grow up?  
 What was the make of your first car?     When is your anniversary?     What is your favorite color?

**Verification Answer to the Chosen question:** \_\_\_\_\_

**Emergency contact person:** \_\_\_\_\_ **Phone:** \_\_\_\_\_









Please check all conditions you currently have or have had

General Questions	Cardiovascular	Kidneys & Urinary Tract	Musculoskeletal
<input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Change in sleep patterns <input type="checkbox"/> Change in activity capacity	<input type="checkbox"/> Angina <input type="checkbox"/> Chest Pain <input type="checkbox"/> Leg cramps <input type="checkbox"/> Murmurs <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Awakening short of breath <input type="checkbox"/> Cardiac catheterization <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Congenital heart defects <input type="checkbox"/> Dizziness when standing quickly <input type="checkbox"/> Heart attacks <input type="checkbox"/> Heart failure <input type="checkbox"/> High or low blood pressure <input type="checkbox"/> Irregular heart rate <input type="checkbox"/> Purple fingers or lips <input type="checkbox"/> Leg pain that resolves with rest <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Varicose veins	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Brown urine <input type="checkbox"/> Dribbling after urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Involuntary urination/incontinence <input type="checkbox"/> Urinating frequently (day) <input type="checkbox"/> Urinating frequently (night) <input type="checkbox"/> Urine hesitancy <input type="checkbox"/> Weak flow <input type="checkbox"/> Frequent bladder infections <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stone	<input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Back pain <input type="checkbox"/> Bursitis <input type="checkbox"/> Gout <input type="checkbox"/> Joint aches <input type="checkbox"/> Neck pain <input type="checkbox"/> Tendonitis <input type="checkbox"/> Abnormal Blood Counts <input type="checkbox"/> Blood clots in legs/lungs <input type="checkbox"/> Bone Marrow Biopsy <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Joint swelling <input type="checkbox"/> Morning stiffness <input type="checkbox"/> Muscle aches
<b>Neurologic and Psychiatric</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Headaches <input type="checkbox"/> Depression <input type="checkbox"/> Meningitis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizure <input type="checkbox"/> Stroke <input type="checkbox"/> Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Memory Loss <input type="checkbox"/> Fainting spells, dizziness <input type="checkbox"/> Head injuries <input type="checkbox"/> Blackouts or near blackouts <input type="checkbox"/> Change in sensation anywhere on your body <input type="checkbox"/> Localized weakness or numbness	<b>Respiratory</b> <input type="checkbox"/> Pleurisy <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Breathlessness when lying flat <input type="checkbox"/> Prolonged cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Frequent infections (bronchitis)	<b>Endocrine</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell <input type="checkbox"/> Abnormal body hair <input type="checkbox"/> Changes in skin texture <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> History of "borderline" diabetes <input type="checkbox"/> Increased loss of hair <input type="checkbox"/> Rheumatism <input type="checkbox"/> Thyroid disease	<b>Gastrointestinal</b> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gallstones <input type="checkbox"/> Reflux <input type="checkbox"/> Vomiting <input type="checkbox"/> Ulcers <input type="checkbox"/> Heartburn <input type="checkbox"/> Hepatitis <input type="checkbox"/> Indigestion <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Anal fissures <input type="checkbox"/> Black tarry stools <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Constipation <input type="checkbox"/> Nausea <input type="checkbox"/> Problems swallowing <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Intestinal obstruction <input type="checkbox"/> Liver disease <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Red blood after bowel movement
<b>Ears, Eyes, Nose &amp; Throat</b> <input type="checkbox"/> Hay fever <input type="checkbox"/> Glaucoma <input type="checkbox"/> Polyps <input type="checkbox"/> Allergy <input type="checkbox"/> Cataracts <input type="checkbox"/> Goiter <input type="checkbox"/> Hoarseness <input type="checkbox"/> Double vision <input type="checkbox"/> Gum problems <input type="checkbox"/> Eye problems <input type="checkbox"/> Ear Infections <input type="checkbox"/> Glasses/contacts <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ear discharge/pain <input type="checkbox"/> Frequent nosebleeds <input type="checkbox"/> Ringing in your ears <input type="checkbox"/> Sinus infections <input type="checkbox"/> Swollen glands	<b>Skin</b> <input type="checkbox"/> Abscess <input type="checkbox"/> Dandruff <input type="checkbox"/> Acne <input type="checkbox"/> Oily skin <input type="checkbox"/> Boils <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Dry skin <input type="checkbox"/> Lumps <input type="checkbox"/> Jaundice <input type="checkbox"/> Psoriasis <input type="checkbox"/> Athlete's foot <input type="checkbox"/> Excessive body odor <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Fungal infections <input type="checkbox"/> Nail problems <input type="checkbox"/> Moles- irregular <input type="checkbox"/> Moles - change/new	<b>Male &amp; Female</b> <input type="checkbox"/> Painful sexual intercourse <input type="checkbox"/> Loss of sexual interest <input type="checkbox"/> Unprotected sex <input type="checkbox"/> Groin itching <input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/> <b>Females Only</b> <input type="checkbox"/> D + C <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hernia <input type="checkbox"/> Fibroids <input type="checkbox"/> Endometriosis <input type="checkbox"/> PMS <input type="checkbox"/> Abn. bleeding between cycles <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Complications with pregnancy <input type="checkbox"/> Heavy bleeding during cycles <input type="checkbox"/> Ovarian cysts <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Postmenopausal symptoms
Provider Notes:			

Patient Signature

Date

Provider Signature

Date

By signing this document you attest to the truth and accuracy of this health survey.

**LAKE WYLIE FAMILY CHIROPRACTIC, INC.  
DOC MARCIA, LLC.**

***Notice of Privacy Practices - Acknowledgement & Consent***

**Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by **Lake Wylie Family Chiropractic, Inc/ Doc Marcia, LLC** or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. A copy of the Notice is available in the waiting room.

**Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Full Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**Optional authorizations** (Please initial/complete the following as you choose):

1 - You have my permission to leave me a voice mail message if the need arises \_\_\_\_\_

2 - You may discuss my health information with the following people (please indicate the names of family members or friends):

\_\_\_\_\_  
\_\_\_\_\_

### Informed Consent To Chiropractic Treatment

A doctor of chiropractic locates, analyzes and treats joint fixation, segmental dysfunction (collectively called a vertebral subluxation complex) and soft tissue lesions. The primary methods the doctor and his associates will use to treat you will be spinal adjustments, myofascial release (trigger point therapy) and exercise therapies. Ancillary therapies used to complement your treatment may include decompressive traction, electrical stimulation, ultrasound and manual therapies.

#### Chiropractic Treatment:

The doctor will use his/her hands or a mechanical device in order to move the joints. You may feel a “click” or a “pop” such as the noise created when a knuckle is “cracked”, and you may feel movement of the joint. In addition, our doctors employ myofascial release methods both before and after they adjust you. Myofascial release techniques require the doctor to push and stretch the muscles to cause them to elongate and release, which may occasionally cause superficial bruising.

#### Risk Associated With Chiropractic Treatment:

As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. 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 other minor complications.

#### Risk Probabilities:

The risks of complications due to chiropractic treatment have been described as “rare”, (Haldeman, Scott, MD, DC), 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 ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

#### Alternative Treatment Options:

1. Self treatment to include over the counter medication.
2. Medical treatment to include the use of prescription drugs and physical therapy.
3. Surgery.
4. Hospitalization.

If the doctor believes that such interventions are warranted he/she will make that recommendation.

#### Risks Of Alternative Treatment:

1. Overuse and improper dosage of over the counter medications may produce undesirable side effects.
2. Overuse and improper dosage of prescribed medications can lead to undesirable side effects and drug dependence.
3. Risks associated with surgery include adverse reactions to anesthesia; surgical errors and protracted periods of convalescence.
4. Risks associated with hospitalization include expense, exposure to disease, and physician and staff errors and omissions.

#### Risk Of Not Receiving Chiropractic Treatment:

Risks associated with not receiving chiropractic treatment may include chronic symptomatology, 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, reduce activities of daily living and make future rehabilitation more difficult.

**Consent To Receiving Chiropractic Treatment:**

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I hereby attest that this form has explained the nature and risks of spinal adjustments, the risk probabilities, alternative treatment options and their associated risks, and the risks of not receiving chiropractic treatment. I understand the risks involved in undergoing treatment and have of my own volition decided to undergo the treatment provided by Lake Wylie Family Chiropractic, Inc/Doc Marcia, LLC.

I hereby give my consent to chiropractic treatment.

Patient Name: \_\_\_\_\_

Witness Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_