Louisville
HEALTHSOLUTIONS
CHIROPRACTIC – REHAB – WELLNESS

Dr. Drew Anderson, D.C.

PLEASE COMPLETE **ALL** OF THE FOLLOWING INFORMATION. THANK YOU.

How did you hear about our office? ☐ Phone Book ☐ Sign ☐ Provider Manual ☐ Patient ☐ Local News ☐ Internet ☐ Other

If referred by a patient, who may we thank for their kind referral? _____

All information is kept STRICTLY CONFIDENTIAL. Please complete as accurately as possible.

- **ABOUT YOU:**

Full Name: _____ Home Telephone: (_____) _____ - _____

Prefer to be called: _____ Cell Telephone: (_____) _____ - _____

Address: _____ Employer: _____

_____ Occupation: _____

City: _____ Work Telephone: (_____) _____-_____

State: _____ Zip: _____ E-mail Address: _____@_____

Date of Birth: _____ / _____ / _____ Age: _____ Marital Status: ___ Single ___ Separated ___ Married

SSN: _____ - _____ - _____ ___ Divorced ___ Widowed

Spouse's Name, if applicable: _____

Spouse's Occupation: _____

- **EMERGENCY CONTACT**

Name: _____ Relationship: _____

Telephone: (_____) _____-_____ Alternate Telephone: (_____) _____-_____

- **INSURANCE INFORMATION**

Name of the responsible party: _____ Patient's relationship to responsible party: _____

Primary Insurance:

Company Name: _____ Policy Holder's Name: _____

Policy ID # _____ Group #: _____ Policy Holder's DOB: _____ / _____ / _____

Secondary Insurance:

Company Name: _____ Policy Holder's Name: _____

Policy ID # _____ Group #: _____ Policy Holder's DOB: _____ / _____ / _____

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Name: _____ Date: _____

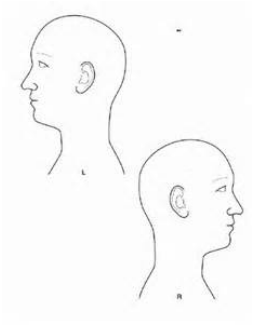
PLEASE ANSWER THE FOLLOWING QUESTIONS:

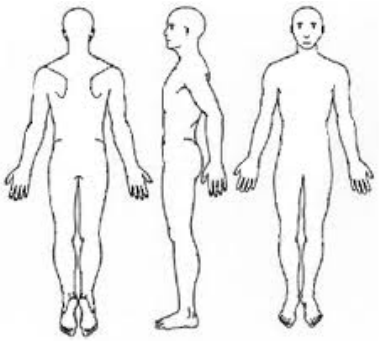
1. What Do you hope to achieve from treatment in this office? (Check all that apply)
   ____ Pain Reduction _____ Correction of the Problem _____ To keep my body as healthy as possible
2. Have you ever been to a chiropractor before? _____ No _____ Yes If "Yes", when? _____
3. Have you ever seen another Doctor for this problem? _____ No _____ Yes If "Yes", when? _____
4. Were you ever injured in an automobile accident either as a passenger or the driver? _____ No _____ Yes If "Yes", when? _____
5. Were you ever injured at work or as the result of employment? _____ No _____ Yes If "Yes", when? _____

CHECK ANY OF THE FOLLOWING THAT PERTAIN TO YOUR MEDICAL HISTORY AND CURRENT SYMPTOMS:

- ☐ Allergies
- ☐ Anemia
- ☐ Arm / Shoulder Pain
- ☐ Arthritis
- ☐ Asthma / Difficulty Breathing
- ☐ Bladder Infection
- ☐ Blurred Vision
- ☐ Buzzing or Ringing in the Ears
- ☐ Cancer
- ☐ Chest Pain / Heart Disease
- ☐ Cold, Tingling Extremities (Arms or Legs)
- ☐ Concentration Loss
- ☐ Constipation / Diarrhea / Colon Disease
- ☐ Convulsions / Epilepsy
- ☐ Cold Sweats
- ☐ Depression
- ☐ Diabetes
- ☐ Disc Problems
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Gallbladder Symptoms
- ☐ Head seems too "heavy"
- ☐ Headaches / Migraines
- ☐ Hepatitis / Liver Symptoms
- ☐ Hip Pain
- ☐ Indigestion / Stomach Problems
- ☐ Insomnia / Sleep Difficulty
- ☐ Joint Problems
- ☐ Kidney Problems
- ☐ Loss of Energy
- ☐ Loss of Memory
- ☐ Loss of Smell / Taste
- ☐ Low Back Pain
- ☐ Menstrual Pain / P.M.S.
- ☐ Mid-back Pain
- ☐ Neck Pain
- ☐ Nervousness
- ☐ Numbness
- ☐ Pain down legs
- ☐ Pinched Nerves
- ☐ Poor Circulation
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Sensitivity to light
- ☐ Sinus Problems
- ☐ Stress / Tension
- ☐ Tight Muscles
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Weight Loss
- ☐ Other _____

PLEASE OUTLINE, ON THE DIAGRAM(S) BELOW, THE AREA(S) OF YOUR DISCOMFORT:





Use the following symbols, as applicable, to diagram areas of discomfort:

A = Aching	N = Numbness
B = Burning	R = Throbbing
C = Cold	S = Stabbing
H = Hypersensitivity	T = Tingling

OUT OF ANY AND ALL OF YOUR CONCERNS, WHICH IS **THE MOST TROUBLESOME** TO YOU? _____

With respect to the condition you indicated in the previous question, please circle the level of pain and/or discomfort that most accurately describes that particular condition.

NO pain ← 0 1 2 3 4 5 6 7 8 9 10 → **WORST** pain imaginable

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Name: _____ Date: _____

HOW HAS THIS AFFECTED YOUR LIFE:

Have you missed work?	Y	N
Has the quality of your work been affected?	Y	N
Are you able to do household chores?	Y	N
Has this problem interfered with your social life?	Y	N
Has it interfered with spending time with family and friends?	Y	N
Has it interfered with your recreational activities (exercise, golf, tennis, fishing, etc.)?	Y	N

Has it affected your life in any other way? _____

OCCUPATIONAL INFORMATION:

Job involves:
- o Sitting
- o Standing
- o Lifting
- o Desk
- o Counter
- o Bending
- o Stooping
- o Twisting
- o Turning

Types of shoes:
- o High heels
- o Boots
- o Arch Supports

Physical activity at work:
- o Sedentary
- o Light Manual Labor
- o Moderate / Heavy Manual Labor

Do any of your work activities aggravate your present main complaints? Please describe:

_____

ACCOUNT INFORMATION

I hereby give my authorization/consent to treat me or my minor child as named herein on this form. Our office policy requires payment in full for all services and goods rendered at the time of your visit to the office, unless other arrangements have been made with the Office Manager. I clearly understand and agree that all services and goods rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I authorize payment of any and all benefits, medical or otherwise, to the physician for benefits due me for the services and/or goods rendered. I further authorize the physician and/or supplier to release my information as required to process any and all insurance claims. I understand the above information in this entirety and hereby guarantee that this form was completed accurately to the best of my knowledge. I also understand that it is my responsibility to inform this office, in a timely manner, of any and all changes to this information.

_____ _____

Patient Signature (Parent or Guardian Signature if Patient is a Minor) Date Signed

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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.

Louisville Health Solutions (hereby referred to as LHS) is required by law to maintain the privacy and confidentiality of your protected health information.

DISCLOSURE OF YOUR HEALTH INFORMATION

Treatment – We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.
Payment – We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.
Workers Compensation – 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 law enforcement officials 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 need to disclose your health information to coroners or medical examiners.

Organ Donation

We may need to disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may need to disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

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 the general public.

Specialized Government Agencies

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

Marketing

We may contact you for marketing purposes or fundraising purposes. We may call you at home to remind you of appointments and may leave a message if there is no answer or you are not available. No health information will be disclosed other than the date and time of your next appointment. We may send a letter, postcard, invitation, or call your home in order to participate in certain events. We may from time to time send you newsletters, birthday cards, reminder cards, holiday greeting cards, thank you cards, or office letters.

Change of Ownership

In the event that LHS is sold or merges, 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. LHS is not required to agree to the restriction. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location. You have the right to copy and inspect your health information. You have the right to request the office amend your protected health information. If your request is denied you will be provided an explanation and about how you disagree with the denial. You have the right to receive an accounting of disclosures of your protected health information. You have a right to a copy of this Notice of Privacy Practices any time upon request.

Treatment

This office uses open room adjusting and therapy. Per request we will accommodate you to a closed room for adjusting and therapy. I am aware that other patients may overhear some of my protect health information during the course of care. I can at any time speak to the doctor in person per my request.

Changes to this Notice of Privacy Practices

LHS reserves the right to amend this Notice of Privacy Practices at any time and will make the new provisions effective for all information it maintains. If you have any questions about any part of this notice or if you want more information contact Nicole at 502-423-0500. If Nicole is not available, you may make an appointment to meet with her in person or via telephone within two working days.

Complaints

Complaints about how LHS has handled your health information should be directed towards Nicole at 502-423-0500. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Ave., S.W.; Room 509F; HHH Building; Washington, D.C. 20201.

I have read the Privacy Notice and understand my rights contained in the notice. By the way of my signature I provide LHS with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations as described in this notice. The staff of LHS has explained the Notice of Privacy Practices to my satisfaction. I am aware that LHS has the right to change the terms of its notice and make any provisions effective for all the protected health information that it maintains.

_____
Patient's Name (PRINT)

_____ _____ _____ _____
Patient's Signature Date Authorized Facility Signature Date

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Informed Consent for Chiropractic Treatment and/or Spinal Decompression Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are risks to chiropractic treatment including, but not limited to:

- ☐ Fractures
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: _____
_____
_____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

To be completed by doctor or staff:

_____
witness to patient's signature

_____
date

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Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only
Height: _____ Weight:_____ Blood Pressure:_____/_____ HR: _____