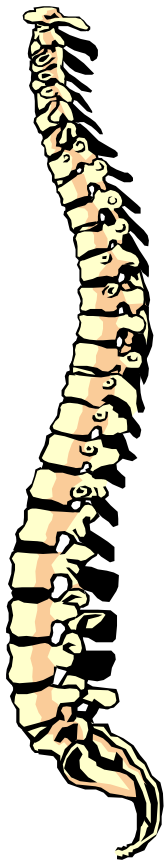
**Lombardi Chiropractic Family Health Center**

Dr. Peter Lombardi

Welcome to our office! It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.



# Chiropractic Health Questionnaire

Name_____ Home Phone_____
Address_____ Work Phone _____
City, State, Zip_____ Email_____
Cell Phone_____ Cell Carrier (circle one): ATT Verizon Sprint Other
Circle Male/Female Age_____ Birth date_____ SS#_____
Occupation_____ Employer_____
Employer Address_____
Marital Status: M W D S Significant Other's Name: _____ No. Of Children____

1. Most patients are referred to our office by a caring family member or friend. What/Who made you decide to visit our office? _____
2. Research shows that your spine should be checked regularly. How many times have you visited a Chiropractor in your lifetime? _____ □ Never
3. When was your last complete spinal examination including x-rays? _____ □ Never
4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? □ Yes □ No
5. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? □ Yes □ No
6. Spinal misalignments can make you feel like you need to twist, stretch, or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? □ Yes □ No
7. Poor posture leads to poor health, often indicating a spinal problem. Please rate your posture:
   Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent
8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days:
   Low – 1 2 3 4 5 6 7 8 9 10 – High
9. Primary Care Physician Name and City _____
10. Please circle or list any health symptoms or health complaints you are experiencing.

| | | | | |
|---|---|---|---|---|
| Neck Pain L/R | Allergies | Thyroid | Constipation | Arm Pain/Numbness L/R |
| Back Pain L/R | Asthma | Diabetes I/II | Menstrual Pain | Headaches/Migraines |
| Leg Pain L/R | Cancer | | | |

11. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?
    1._____ 2. _____ 3. _____ (Use back if necessary)
12. List any surgeries you have had. _____
13. Daily trauma, auto accidents, and work injuries can cause serious spinal problems. When was your most recent injury: at home? _____ car accident? _____ slip or fall? _____
14. Spinal Health is especially important during pregnancy.
    Is there any chance that you are pregnant? □ Yes □ No
15. Do you smoke? □ Yes □ No
16. Sleeping position: □Back □Stomach □Side L/R
17. Exercise level: Low – 1 2 3 4 5 6 7 8 9 10 – High
18. Right Handed/ Left Handed
19. Do you currently take Vitamins/Supplements? □ Yes □ No
20. If the doctor recommends Chiropractic Care to help you, are you willing to follow his recommendations completely? □ Yes □ No

The above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Lombardi Chiropractic
Family Health Center

# Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation.

**Health:** A state of optimal physical, mental, and social well-being not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 21 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination. We encounter non-chiropractic or unusual findings; we will advise you. If you desire advice, diagnosis or treatment for those findings, we recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by other. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct the vertebral subluxations.

I,_____have read and fully understood the above statements.

All questions regarding the doctor's objectives pertaining to my case in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature_____ Date_____

Dr. Peter L. Lombardi
1116 Upper Lenox Avenue, Oneida, New York 13421
Office: 315-363-4114 • Fax: 315-363-8655
www.lombardichiropractic.com

# Photo Release

This is to acknowledge my approval to allow Lombardi Chiropractic Family Health Center to take my picture for in-office use. **This photo or any information will never be shared with any outside source.**

Patient Name: _____

Patient Signature: _____

Date: _____

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**QUADRUPLE VISUAL ANALOGUE SCALE**

Patient Name _____ Date _____

**Please read carefully:**

**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

**Example:**

Headache Neck Low Back

**No pain** _____ **worst possible pain**

**0 1 (2) 3 4 (5) 6 7 (8) 9 10**

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**1 – What is your pain RIGHT NOW?**

**No pain** _____ **worst possible pain**

**0 1 2 3 4 5 6 7 8 9 10**

**2 – What is your TYPICAL or AVERAGE pain?**

**No pain** _____ **worst possible pain**

**0 1 2 3 4 5 6 7 8 9 10**

**3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

**No pain** _____ **worst possible pain**

**0 1 2 3 4 5 6 7 8 9 10**

**4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**

**No pain** _____ **worst possible pain**

**0 1 2 3 4 5 6 7 8 9 10**

**OTHER COMMENTS:**

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

# Financial Policy

Our Team would like to take a moment and welcome you to our practice. Since you have made the first step in entrusting us with your health, we would like to express our commitment and dedication to making sure you receive the best care possible!

Please read our financial policies below:

**Fee-for Service**: Our patients pay out of pocket for services rendered at the time of appointment. We accept Cash, Credit Card, or Check. I understand that I am financially responsible for any charges incurred at this office.

**Insurance**: Our office is not "in-network" with any insurance company. As a courtesy, we can verify your "out of network" chiropractic benefits, and submit claims to your insurance company on your behalf. You will get reimbursed directly from your insurance company, depending on your plan and benefits.

**Medicare**: We are a "non participating" provider of Medicare. This means that a payment will be required from you, the patient, at the time services are rendered. We will submit claims to Medicare on your behalf. You will get reimbursed directly from Medicare, depending on your plan and benefits.

**I have read this document and understand my obligations for payment for care in this office.**

Name: _____
Signature:_____ Date: _____

# Informed Consent for Chiropractic Treatment and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Limitless Life Chiropractic.

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care in general include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment, which the doctor feels at the time, based on the facts then known, to be in my best interest.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the doctor or intern, affiliated with Limitless Life Chiropractic to perform such. 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.

Name: _____
Signature:_____ Date: _____

# HIPAA Privacy Rule

# Receipt of Notice of Privacy Practices

# Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement

- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness_____

Printed Name of Individual or Legal Representative _____

Date: _____

***FOR OFFICE USE ONLY***

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

☐ Individual refused to sign

☐ Communication barrier prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Others (please specify)

_____

_____