Welcome To Our Practice!

We have been In practice for over 23 Years! We are delighted that you have chosen us! Some things you should know about today and any upcoming appointments.

All new patients must undergo a New Patient Consultation & Examination by the Dr. We understand you may have had other chiropractic care or have been through this before but if I accept you as a patient and you accept me as your Dr. I am responsible for your care & can not rely on other Dr's findings. This a VA Board of Medicine Policy.

We do not offer treatment on the same day as an examination.
No exceptions.

We do not have x-ray services on-site but can easily provide a referral for x-ray's ad may require this before we begin treatment. Any x-ray or M.R.I's taken within the last three years should be provided or copies of reports will need to be faxed to our office. Dr. Lauterbach will make a clinical decision, based upon the examination if this is necessary prior to treatment.

Please fill out the attached forms (yes we do not like forms either) Each page must be signed and dated at the bottom. If you need assistance, please let us know.

Thank You For allowing Us to Serve You!

Lauterbach Chiropractic, Acupuncture & Laser Center

Welcome!

These forms help us gather information on your medical history and current state of your health. Please make sure to fill this form out completely, including signing and dating at the bottom of each page.

ABOUT YOU:	
Name:	
Date of Birth:	Age:
Social Security Number:	
Address:	
City, State, Zip:	
Home Phone #: ( )	
Cell Phone #: ( )	
Cell Phone Carrier:	
Email Address:	
Marital Status:	
Spouse's Name:	
Referred By:	

IN EVENT OF EMERGENCY:	
Emergency Contact:	
Relationship:	
Emergency Phone # 1: ( )	
Emergency Phone # 2: ( )	

INSURANCE INFORMATION:	
Policy Holder:	
Date of Birth:	Age:
Address:	
City, State, Zip:	
Relationship:	
Company Name:	
Policy #:	
Group #:	

EMPLOYMENT:	
Are you a student?	Yes, full time / Yes, part time / No, I am not
Are you employed?	Yes, full time / Yes, part time / No, I am not
Title:	
Employer:	
Address:	
City, State, Zip:	
Work Phone # : ( )	

PERSONAL INFORMATION
Who is Your Primary Care Physician?
Have you seen them for this condition? Y / N If Yes When & result:
Have you had an X-Ray or M.R.I. for this condition? Y / N If Yes When & Where?
Please List Current Medications:
Have you had previous chiropractic care? If yes When & where?
If you are accepted as a patient is there anything you would like us to know?

Patient Signature: Date: / /

Lauterbach Chiropractic
Acupuncture & Laser center

202 Turkeysag Trail Suite 5
Palmyra, VA 22963
434.591.0900
DrLauterbach.com

Please complete this questionnaire by answering each section as completely as possible, to the best of your knowledge, and as you feel right now. It is designed to give us information as to how your condition has affected your ability to manage in everyday life.

Show where it hurts on the diagrams on the right → → →

A = ACHE

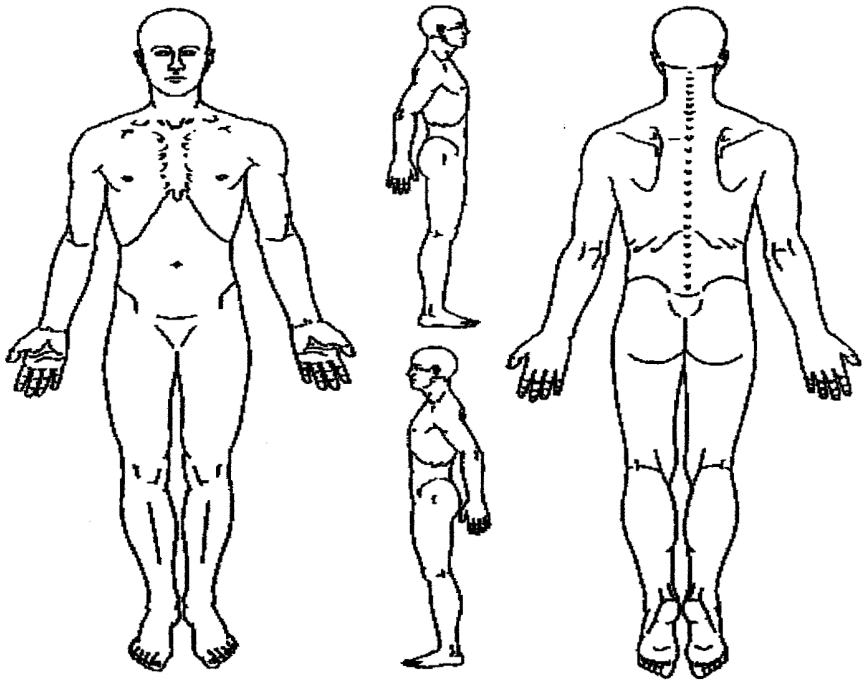
B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER_____



Briefly describe your symptoms:

_____

_____

When/how did your symptoms start?

_____

_____

How has the severity of your condition changing, since its onset? (circle)

Much worse Worse A little worse No change A little better Better Much better

My pain when at its worst is (circle): No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

My pain when at its least is (circle): No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

My average pain level is (circle): No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

How often do you experience your symptoms? (circle)

Constantly (100-76% of the time) Frequently (75-51% of the time)

Occasionally (50-26% of the time) Intermittently (25-0% of the time)

Does this pain shoot, radiate or travel in your body? Where?_____

What activities/treatments aggravate your condition/pain?_____

What activities/treatments lessen your condition/pain?_____

Are you experiencing any numbness, tingling or spasms? Where?_____

How much have your symptoms interfered with your usual daily activities? (circle)

Patient Signature: _____ Date: _____ / _____ / _____

Modified George's Cerebrovascular Craniocervical Function History:

Have you ever been diagnosed with or treated for any of the following?

1. High Blood Pressure (hypertension) ☐Yes ☐ No
2. Hardening of the arteries (arteriosclerosis) ☐Yes ☐ No
3. Diabetes ☐Yes ☐ No
4. Heart or blood vessel diseases ☐Yes ☐ No
5. Bone spurs on the neck bones (cervical spondylosis) ☐Yes ☐ No
6. Whiplash injury (flexion-extension injury of the cervical spine) ☐Yes ☐ No
7. Have you or any of your immediate relatives ever suffered a stroke or mini-stroke (CVA or TIA)? ☐Yes ☐ No
8. Were you ever a smoker? ☐Yes ☐ No
   If yes, from _____ to _____
9. Do you take blood-thinning or anti-platelet medications? ☐Yes ☐ No
   If so, which?_____
10. (Women Only) Have you ever taken oral Contraceptives? ☐Yes ☐ No
    If yes, from _____ to _____

Have you ever had any of the following, even as short or temporary attacks?

1. Dizziness, unsteadiness, giddiness, or vertigo? ☐Yes ☐ No
2. Drop attacks, loss of consciousness, even momentary blackouts or sudden collapse without loss of consciousness? ☐Yes ☐ No
3. Diploplia - Blurred or Double Vision? Partial or complete loss of vision in one or both eyes? ☐Yes ☐ No
4. Dysarthria- Slurred speech or other speech problems/difficulties? ☐Yes ☐ No
5. Dysphagia - Difficulty swallowing? ☐Yes ☐ No
6. Ataxia of gait - Difficulty walking due to lack of coordination of extremities, falling to one side, or any of the following: weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? ☐Yes ☐ No
7. Nausea – Associated with movement or other symptoms listed here? ☐Yes ☐ No
8. Numbness on one side of the face and/or body? ☐Yes ☐ No
9. Nystagmus – abnormal involuntary eye movements? ☐Yes ☐ No
10. Altered mental status including lack of understanding? ☐Yes ☐ No
11. Hearing loss, ringing, buzzing or any noise in one or both ears? ☐Yes ☐ No
12. Sudden severe pain in the side of the head and/or neck which is different from any other pain you have ever had? ☐Yes ☐ No

Patient Signature: _____ Date: _____ / _____ / _____

Past Medical History: *Check all boxes that apply*

1. General Health:
- ☐ Recent weight change
- ☐ On-going fever/chills
- ☐ Unexplained sweats
- ☐ Reoccurring allergies
- ☐ Anemia
- ☐ Unusual bleeding/bruising
- ☐ Malaise / fatigue / weakness
- ☐ Cancer
- ☐ Difficulty breathing with exertion
- ☐ Other_____

2. Skin / Hair / Nails:
- ☐ Change in skin color or texture
- ☐ Rashes / itching / lesions
- ☐ Skin growths
- ☐ Change in hair growth
- ☐ Change in shape of nails
- ☐ Change in condition of nails
- ☐ Other_____

3. Eyes / Ears / Nose / Throat:
- ☐ Visual problems
- ☐ Corrective lenses
- ☐ Redness / tearing / itching
- ☐ Pain in eyes
- ☐ Glaucoma
- ☐ Detached retina
- ☐ Difficulty hearing / deafness
- ☐ Ringing in ears / dizziness
- ☐ Ear pain
- ☐ Nosebleeds
- ☐ Changes in ability to smell
- ☐ Excessive sneezing
- ☐ Nasal growths / discharge
- ☐ Nose pain
- ☐ Sinus infection
- ☐ Change in voice / hoarseness
- ☐ Enlarged / painful glands
- ☐ Changes in ability to taste
- ☐ Other_____

4. Cardiovascular System:
- ☐ Heart attack
- ☐ Shortness of breath from exercise
- ☐ Chest discomfort / pain
- ☐ Palpitations
- ☐ Edema
- ☐ Fainting
- ☐ Calf pain when walking
- ☐ High blood pressure
- ☐ Past heart disease
- ☐ Other_____

5. Respiratory System:
- ☐ Difficulty breathing
- ☐ Abnormal cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ C.O.P.D. / emphysema
- ☐ Tuberculosis
- ☐ Smoke / tobacco use
- ☐ Other_____

6. Gastrointestinal System:
- ☐ Changes in appetite
- ☐ Food allergy / intolerance
- ☐ Nausea / vomiting
- ☐ Vomiting blood
- ☐ Peptic / duodenal ulcer
- ☐ Indigestion / heart burn
- ☐ Abdominal pain
- ☐ Abnormal flatulence (gas)
- ☐ Changes in bowel habits
- ☐ Diarrhea
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Gallbladder surgery
- ☐ Liver disease
- ☐ Pancreas disease
- ☐ Excessive alcohol use
- ☐ Other_____

7. Musculoskeletal System:
- ☐ Arthritis (Type:_____)
- ☐ Joint stiffness / pain
- ☐ Joint swelling
- ☐ Change in range of motion
- ☐ Joint dislocation
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Muscle wasting
- ☐ Muscle pain
- ☐ Strain / sprain
- ☐ Fractured bone
- ☐ Other_____

8. Neurological System:
- ☐ Headaches
- ☐ Seizures
- ☐ Dizziness/fainting
- ☐ Sensory disturbances
- ☐ Localized weakness
- ☐ Stroke / CVA / TIA
- ☐ Vertebral disc herniation
- ☐ Brain / spinal cord injury
- ☐ Other_____

9. Endocrine System:
- ☐ Heat / cold intolerance
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Other_____

10. Renal / Urinary System:
- ☐ Frequent urination
- ☐ Increased thirst
- ☐ Urinary urgency / pain
- ☐ Unusual urine color or smell
- ☐ Blood in urine
- ☐ Difficulty holding urine
- ☐ Difficulty passing urine
- ☐ Urethral discharge
- ☐ Flank / side pain
- ☐ Urinary tract infection
- ☐ Kidney disease / stone
- ☐ Dialysis
- ☐ Other_____

Patient Signature: _____ Date: _____ / _____ / _____

Past Medical History (continued) : *Check all boxes that apply*

11. Psychological:
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Post Traumatic Stress
- ☐ Anorexia/bulimia
- ☐ Other_____

12. Breasts (Male & Female):
- ☐ Breast lumps / masses / growths / pain / tenderness
- ☐ Dimples in breast
- ☐ Changes in color/shape/size
- ☐ Nipple discharge/bleeding
- ☐ Breast implants
- ☐ Other_____

13. Reproductive System:
- ☐ Unusual/missed periods
- ☐ Genital lesions
- ☐ Genital mass/growth/pain
- ☐ Sexually transmitted disease
- ☐ H.I.V./A.I.D.S.
- ☐ Other_____

List all medications, herbal supplements, vitamins and minerals you take and their doses:

_____

_____

_____

List all surgeries, dates and reasons:

_____

_____

_____

List all hospitalizations, dates and reasons:

_____

_____

_____

Authorization and Acknowledgement

I have received a copy of my **Informed Consent Release.** I have read this authorization and I understand that it explains: (1) the risks and benefits of chiropractic care, (2) the risks and benefits of alternative treatments and (3) risks and benefits of not receiving or undergoing any treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to chiropractic care.

I have reviewed copy of the **Protected Health Information & Hipaa** policy. I have read this authorization and I understand that it explains circumstances in which I permit my health information to be used and shared with others. I authorize the uses and disclosures described in this authorization.

I Understand and agree that health/accident insurance policies are an arrangement between me and and insurance carrier. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. We will file and bill all insurance on your behalf. Co-pays & deductibles are your responsibility. All Accounts past 60 days are forwarded for collection and additional cost of collection, interest and attorney fees may apply.

I authorize a **Release of Healthcare Information** to Dr. Lauterbach for any records relevant to my physical condition including but not limited to X-ray, CT, or MRI reports and/or Emergency Room or physician treatment records.

I understand all portions of this questionnaire and all answers are true and accurate to the best of my knowledge. My initials elsewhere in this document are equivalent to signatures.

Patient Signature: _____ Date: _____ / _____ / _____