Welcome to Delta Chiropractic Center of Lansing!

517.321.3030

We are pleased that you have chosen to join our team as you seek answers to your health goals. The following information will help us find the best answers to your challenges and goals. Please fill out each page completely and print it off and bring it with you to your first visit. Any blank lines will have to be filled out before your consultation, exam and treatment. While ALL information is crucial, items with an asterisk (*) MUST be filled out.

If you need to change your appointment, we do require a 24 hour notice, so please let us know at least 24 hours prior to that date. We have many patients waiting for open appointment times, so we'd like to be able to allow them access to that appointment if you cannot keep it.

Your for Better Health,
Delta Chiropractic Center of Lansing
6130 W. Saginaw Hwy.
Lansing, MI 48917

PATIENT INFORMATION

A. Name *_____Date _____Birthdate *_____

Address *_____City *_____State_____Zip _____

Home # _____Cell# *_____Work # _____SS# _____

E-mail Address *_____ Sex *M F* Marital Status *S M W D* # Children ____

Referred By _____ Insurance Company *_____

Employer _____ Job Title _____Job Description _____

Name of Primary Care Physician: _____May we send a report to them? Y N

B. Medications: _____

Vitamins: _____Allergies to Medications: _____

Prev. Chiro. Care: _____ Prev. x-rays: _____

Your current weight: _____ Height _____ Shoe size _____ **Sleeping posture** ❑ side ❑ stomach ❑ back

Previous car accidents or falls: *_____

Surgeries: _____ Broken bones: _____

Other traumas? _____ Previous Stroke or TIA? *_____

Current Hobbies, Sports, Activities: _____

Is there a chance that you could be pregnant? Y N

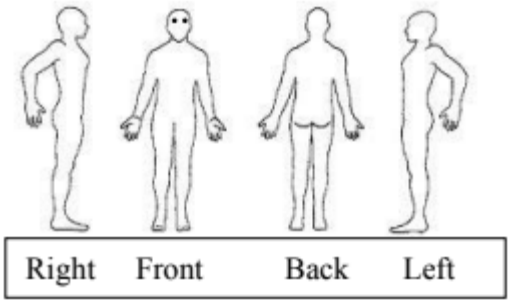
What are your chief complaints? PS-Pain Scale 1-10

1.*_____ PS*___

2._____ PS ___

3. _____PS ___

4. _____PS ___



Circle on the body any area you're currently having pain

Date First Noticed _____ Ever had it before? Y N

It was caused by _____ Missed work due to this? Y N

What have you done to treat this? _____

Other professionals seen for this? _____

Is this a car or work accident? Y N Date and time of accident _____

Hurts more when: Sitting / Bending / Lifting / Twisting / Riding in car / Working / Sleeping / Standing / House Work / Walking / Straining / Constant / Other: _____

Hurts less when: ❑ OTC meds ❑ Prescription ❑ Rest ❑ Lay down ❑ Sleep ❑ Sit ❑ Stretch ❑ More active ❑ With ice ❑ With heat ❑ Massage ❑ Other _____

My goals for my care here:

*_____

Rate your pain: 1 2 3 4 5 6 7 8 9 10 ___ (P)

Rate your posture: 1 2 3 4 5 6 7 8 9 10 ___ (A)

Rate your flexibility: 1 2 3 4 5 6 7 8 9 10 ___ (R)

Rate your muscle tension: 1 2 3 4 5 6 7 8 9 10 ___ (T)

Energy Level: No Energy 1 2 3 4 5 6 7 8 9 10 Energetic

Stress Level: No Stress 1 2 3 4 5 6 7 8 9 10 Much Stress

Spiritual Interest: No Interest 1 2 3 4 5 6 7 8 9 10 Very Interested

How do your symptoms impact your daily activities?

Neck:_____

Low back:_____

Other:_____

What do you wish you could do better if we fix your problem?

_____

Any problems with systems:

Vision No__Yes__ If yes explain:_____

Bones/Joints No__Yes__ If yes explain:_____

Heart/Circulation No__Yes__ If yes explain:_____

Breathing/Lungs No__Yes__ If yes explain:_____

Immune Challenges No__Yes__ If yes explain:_____

Digestion No__Yes__ If yes explain:_____

Urinary No__Yes__ If yes explain:_____

Skin/Connective Tissue No__Yes__ If yes explain:_____

Endocrine/Hormones No__Yes__ If yes explain:_____

Emotional/Stress No__Yes__ If yes explain:_____

Neurologic No__Yes__ If yes explain:_____

Pertinent Family History No__Yes__ If yes explain:_____

CONSENT TO RELEASE INFORMATION

As a patient of Delta Chiropractic Center, who do you authorize us to release scheduling and/or care and progress information to?

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Primary Doctor: _____ Phone:_____

CONTACT INFORMATION

When we need to contact you, what phone number do you prefer we use (including leaving you a message)?

Phone #: _____

Sometimes we may need to contact you via email, which email do you prefer we use?

Email: _____

By signing below, you are giving our office permission to send you appointment reminders/messages via text/email.

_____
Printed Name

*_____ _____
Signature Date

Patient Privacy Policies

To Contact Us

If you would like further information about our privacy policies and practices, a copy is available upon request at our office, or contact us at:

Delta Chiropractic Center

6130 W. Saginaw Hwy.

Lansing, MI 48917

517.321.3030

This notice will expire seven years after the date upon which the record was created.

By signing below, I acknowledge that I have been offered a copy of the Patient Privacy Policies.

_____ _____

Patient Name Printed Date

*_____ _____

Patient Signature Provider Representative

_____ _____

Guardian Printed Name Guardian Signature

_____

Guardian's relationship to, or other authority to act for, the patient

Authorization and Consent

1) **Assignment of benefits:** I hereby authorize Delta Chiropractic Center and Active Role Chiropractic to examine and treat my condition as they deem appropriate. I authorize payment directly to the provider of any and all benefits for charges for exams and care received by me or my dependents. I also authorize benefit payers to release all information requested regarding such benefits and payment to the provider above. I also authorize the provider to release all information needed to obtain those benefits. I also agree that I am responsible for all bills incurred at this office. As an estimate of the fees for your proposed treatment plan, we may bill your insurance company for your exam and x-rays, as well as $60 per adjustment. I understand that while DCC will do their best to monitor my benefits, they highly recommend that I contact them also, because what is not covered by insurance, I will pay. Delta Chiropractic Center will not be held responsible for any medical condition or diagnosis. **Initial Here:** *____

2) **Informed Consent:** Chiropractors do not diagnose diseases. Our job is to find areas of nerve interference and to remove it. We suggest that you visit your medical doctor in order to care for any health concerns other than Nerve Impingement. We also want you to realize there are risk factors involved in any form of health care. Surgery may have death risk factors of anywhere from 1/1,000 to 1 in 100. Medication may cause serious reactions in 1/100,000 to 1 in a thousand cases. Proper chiropractic adjustments almost never result in serious reactions: less than 1 in a million, but may include sprain, cerebrovascular accident or disc damage. The risks of refusing chiropractic care include degeneration, nerve damage, and increased duration, frequency, and intensity of your symptoms. **Initial Here:** *____

3) X-rays:

a. I understand that all x-rays are taken to provide more accurate information concerning my care. The value of this information outweighs the minimal radiation risks involved. (The radiation in these studies is very small, and is minimized by our regular upkeep and calibration of our equipment. You receive more radiation from your television set, from natural background radiation, and even from the foods you eat. The doctor will not ask you to do anything he does not ask of his own family.) **Initial Here:** *____

b. I am not pregnant. **Initial Here:** *____

c. I understand and agree that fees paid to the office for x-rays are for information and analysis only. **By state law**, I have the right to obtain the information gained from these x-rays, but **the films themselves will remain the property of Delta Chiropractic Center** and **the original films will not be allowed to leave the office**. Copies can be obtained for $10.00 per view, with three days notice. A brief written or oral report may be obtained at no charge. **Initial Here:** *____

Signature: *_____ Date: _____