

**Living with Motion Chiropractic**  
PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION. THANK YOU.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Acct. #: \_\_\_\_\_

How did you hear about our office?  CBYP online  Sign  Google  Yahoo  Church Bulletin  Patient  Other \_\_\_\_\_

If referred by a friend or patient, whom 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: \_\_\_\_\_

Mobile Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_

City: \_\_\_\_\_

Occupation: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Single  Separated  Divorced

Email Address: \_\_\_\_\_

Married  Widowed

Driver License No. \_\_\_\_\_ State: \_\_\_\_\_

• MEDICAL / HEALTH CARE HISTORY •

Please list any prescription AND/OR over-the-counter (OTC) medications you are presently taking: \_\_\_\_\_  
\_\_\_\_\_

Please list any illnesses, accidents, surgeries and/or treatments with dates: \_\_\_\_\_  
\_\_\_\_\_

Please list any nutrients you are currently taking: (We offer to evaluate the formulations of your supplementation) \_\_\_\_\_  
\_\_\_\_\_

**PRIMARY INSURANCE**

Policy Holder's Name: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_

Ins. Co. Name: \_\_\_\_\_ Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

• EMERGENCY CONTACT •

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PRIMARY PHYSICIAN**

I authorize this office to communicate to my primary physician about the care I receive.

Primary Physician: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_

Physician Phone #: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

1. Have you ever been to a chiropractor before?  No  Yes If "Yes", when? \_\_\_\_\_
2. Have you ever seen another Doctor for this problem?  No  Yes If "Yes", when? \_\_\_\_\_
3. Were you ever injured in an automobile accident either as a passenger or the driver?  No  Yes If "Yes", when? \_\_\_\_\_
4. Were you ever injured at work or as the result of employment?  No  Yes If "Yes", when? \_\_\_\_\_

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

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

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Allergies                                 | <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Neck Pain        |
| <input type="checkbox"/> Anemia                                    | <input type="checkbox"/> Disc Problems                  | <input type="checkbox"/> Numbness         |
| <input type="checkbox"/> Arm / Shoulder Pain                       | <input type="checkbox"/> Dizziness                      | <input type="checkbox"/> Pain down legs   |
| <input type="checkbox"/> Arthritis                                 | <input type="checkbox"/> Ear Infections                 | <input type="checkbox"/> Pinched Nerves   |
| <input type="checkbox"/> Asthma / Difficulty Breathing             | <input type="checkbox"/> Fever                          | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Blurred Vision                            | <input type="checkbox"/> Headaches / Migraines          | <input type="checkbox"/> Scoliosis        |
| <input type="checkbox"/> Buzzing or Ringing in the Ears            | <input type="checkbox"/> Hip Pain                       | <input type="checkbox"/> Sinus Problems   |
| <input type="checkbox"/> Cancer                                    | <input type="checkbox"/> Indigestion / Stomach Problems | <input type="checkbox"/> Stress / Tension |
| <input type="checkbox"/> Chest Pain / Heart Disease                | <input type="checkbox"/> Joint Problems                 | <input type="checkbox"/> Tight Muscles    |
| <input type="checkbox"/> Cold, Tingling Extremities (Arms or Legs) | <input type="checkbox"/> Low Back Pain                  | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Constipation / Diarrhea / Colon Disease   | <input type="checkbox"/> Menstrual Pain / P.M.S.        | _____                                     |
|  | <input type="checkbox"/> Mid-back Pain                  |   |

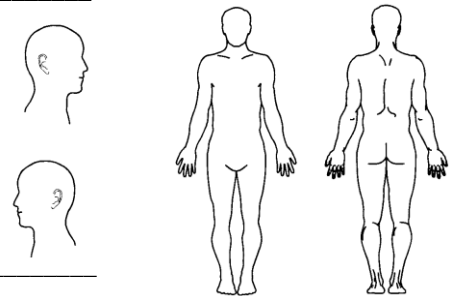
**PRIMARY CONDITION – PLEASE DESCRIBE ONE AREA OF COMPLAINT**

Please describe your primary complaint: \_\_\_\_\_  
 When did it start? \_\_\_\_\_ Have you had it in the past?  Y  N When: \_\_\_\_\_  
 Please mark the appropriate space: The pain is  constant  it comes and goes  
 On a scale from 1-10 with 10 being the worst, circle the level of pain 1 2 3 4 5 6 7 8 9 10  
 Please mark the space(s) that best describe the pain:  
 Sharp/Stabbing  Burning  Dull  Tingling  Numbness  Other \_\_\_\_\_  
 Does your pain travel from the point of pain?  Y  N If yes, where? \_\_\_\_\_  
 Have you seen any other doctors for this condition?  Y  N Name: \_\_\_\_\_  
 What makes it better: \_\_\_\_\_ Worse: \_\_\_\_\_  
 Do any of the following aggravate your condition?  Walking  Sitting  Coughing  
 Sneezing  Driving  Breathing  Working  Bowel Movements  Sleeping  
 Is this the result of an automobile accident?  Y  N Work Related Injury:  Y  N  
 If yes to either question above, please explain: \_\_\_\_\_  
 What other treatment have you had for this condition: \_\_\_\_\_  
 Chiropractic  Physical Therapy  Surgery  Other \_\_\_\_\_  
 \*DOCTOR USE ONLY: \_\_\_\_\_

Please mark your areas of pain  
On the figure below

++ Sharp/Stabbing    ## Burning  
XX Tingling/Numb    00 Dull

R      L      L      R



**SECONDARY CONDITION (If Applicable)**

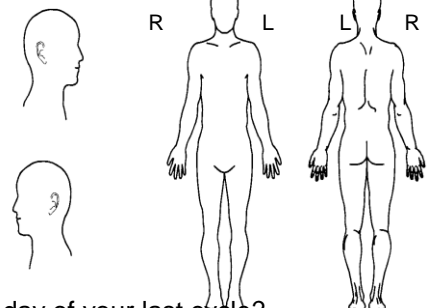
Please describe your secondary complaint: \_\_\_\_\_  
 When did it start? \_\_\_\_\_ Have you had it in the past?  Y  N When: \_\_\_\_\_  
 Please mark the appropriate space: The pain is  constant  it comes and goes  
 On a scale from 1-10 with 10 being the worst, circle the level of pain 1 2 3 4 5 6 7 8 9 10  
 Please mark the diagram to show the location of your secondary condition.  
 Mark any other complaints here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please mark your areas of pain

On the figure below

++ Sharp/Stabbing    ## Burning  
XX Tingling/Numb    00 Dull

R      L      L      R



**Female Only:**

Are you currently having menstrual cycles?  Yes  No If yes, when was the first day of your last cycle?  
 \_\_\_\_\_

Is there any chance you are pregnant?  Yes  No

If no, please sign here: \_\_\_\_\_

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

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

**Family History:** Insert age and check any box that applies

	Age (if living)	Heart Dx	High Cholest	High BI Pressure	Diabetes	Cancer	Anxiety	Neck Pain	Low Bck Pain	Smoker	Headaches	Obesity
Self												
Mom												
Dad												
Brother												
Sister												
Other__												

**Doctor's Use Only:** \_\_\_\_\_

Please circle the following activities that are affected by your current condition:

- |                    |                    |                   |                   |
|--------------------|--------------------|-------------------|-------------------|
| Bathing            | Cooking            | Laying Down       | Sleep             |
| Bending            | Daily Pet Care     | Lifting Items     | Sneezing          |
| Brushing Teeth     | Dressing           | Reading           | Sports            |
| Caring for Family  | Swallowing         | Reaching          | Static Sitting    |
| Carrying Items     | Driving            | Running           | Static Standing   |
| Changing positions | Eating             | Shaving           | Washing body/hair |
| Climbing stairs    | Exercising         | Showering         | Work activities   |
| Computer Use       | Getting out of bed | Sexual activities | Yard Work         |
| Concentration      | Household Chores   |                   |                   |

**LIFESTYLE:** Your lifestyle, diet and exercise habits play an extremely important role in your overall health and risk of chronic disease. The following questions are designed to help us understand your habits and your desires and commitments to make changes to those habits if necessary.

**Diet:**

1. How much water do you drink a day? \_\_\_8 oz glasses What kind? Tap Filtered Distilled
2. How many times do you eat fast food each week? \_\_\_\_\_
3. Y N Do you drink caffeinated beverages? If yes, what kind and how many daily? \_\_\_\_\_
4. Y N Do you drink alcohol? If yes, what kind and how many drinks a week? \_\_\_\_\_
5. Y N Do you smoke? If yes, how many packs a day? \_\_\_\_\_
6. How many servings of fruits and vegetables are you eating a day? 0 1 2 3 4 5 6 7 8 9 10  
1 medium fruit = one serving 1 cup raw vegetables = one serving\
7. Do you have any food allergies? If yes, please name: \_\_\_\_\_
8. On a scale of 1 to 10, what level of stress do you experience daily? (low) 1 2 3 4 5 6 7 8 9 10 (high)

**Body Composition and Exercise:**

1. Y N Are you at your ideal weight? Current Weight\_\_\_\_\_ If no, what is your desired weight? \_\_\_\_\_  
Are you interested in weight management? Y N
2. Y N Do you engage in any cardiovascular exercise (aerobics, swimming, walking, etc)?  
If so, which activities? \_\_\_\_\_ Days Per Week \_\_\_\_\_ Time \_\_\_\_\_
3. Y N Do you do any form of resistance exercises (lift weights) on a consistent basis? Days Per Week \_\_\_\_\_
4. Y N Do you ever experience pain after exercising? If so, where? \_\_\_\_\_ Type of pain \_\_\_\_\_
5. Y N Do you participate in any sports? If so, which ones are your favorites? \_\_\_\_\_
6. What are your health goals for exercise in the upcoming 6 months? \_\_\_\_\_
7. On a scale of 1 to 10, what is your commitment to making a lifestyle improvement? 1 2 3 4 5 6 7 8 9 10

# Living with Motion Chiropractic

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

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.

Living with Motion Chiropractic 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 protected health information to doctors, hospitals, and other healthcare professionals for their provision, coordination, or management of your health care and related services.
- **Payment** - We may disclose your protected health information to insurance providers for the purpose of payment or healthcare operations.
- **Workers' Compensation** - We may disclose your protected health information to comply with State Workers' Compensation Laws.
- **Emergencies** - We may disclose your protected 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 protected 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 protected health information in the course of any administrative or judicial proceeding or in response to a legal order.
- **Law Enforcement** - We may disclose your protected 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 protected health information to coroners or medical examiners.
- **Organ Donation** - We may need to disclose your protected health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- **Research** - We may need to disclose your protected health information to researchers conducting research that has been approved by an institutional Review Board.
- **Public Safety** - It may be necessary to disclose your protected 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 protected 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 confirm your appointments and may leave a message if there is no answer or you are not available. No protected 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.
- **Referrals** - We may acknowledge and express appreciation to a patient, physician, or other person who has referred you to Living with Motion Chiropractic for care. No protected health information will be disclosed other than your identity as it is known to the person referring you.
- **Change of Ownership** - In the event that Living with Motion Chiropractic is sold or merges, your protected health information / record will become the property of the new owner.

## YOUR INDIVIDUAL RIGHTS

- **Your Protected Health Information Rights** - You have the right to request restrictions on certain uses and disclosures of your protected health information. Living with Motion Chiropractic is not required to agree to the restriction. You have the right to have your protected health information received or communicated through an alternative method or sent to an alternative location. You have the right to copy and inspect your protected 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 can 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.
- **Changes to this Notice of Privacy Practices** - Living with Motion Chiropractic 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 Dr. Lucas Reineck at 513-831-4433.
- **Complaints** - Complaints about how Living with Motion Chiropractic has handled your health information should be directed towards Dr. Lucas Reineck at 513-831-4433. 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.

## ADDITIONAL INFORMATION

- **Treatment** - This office uses open room adjusting and therapy. Per request we will accommodate you to a closed room for adjusting and therapy.

This notice is effective as of Nov 1, 2008.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature I provide Living with Motion Chiropractic 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 Living with Motion Chiropractic has explained the Notice of Privacy Practices to my satisfaction. I am aware that Living with Motion Chiropractic 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