Name:_____

Welcome to our wellness center,

Today we are here to discover your goals and priorities as it relates to your health and wellness.
Your answers will help us determine how we can best help you.

Let's get started…

On a scale of 1 – 10, rate the importance for you to achieve the following by **placing an X** over the number, (1 = not important 10 = necessary), and **circle** your current level in each area (0 = poor, 10 = excellent)

Example: Increase my energy (necessary, below average currently)	1	2	3	(4)	5	6	7	8	9	X
Reduce my pain	1	2	3	4	5	6	7	8	9	10
Reduce my anxiety	1	2	3	4	5	6	7	8	9	10
Reduce medications	1	2	3	4	5	6	7	8	9	10
Increase my energy	1	2	3	4	5	6	7	8	9	10
Increase my mobility	1	2	3	4	5	6	7	8	9	10
Improve my sleep	1	2	3	4	5	6	7	8	9	10
Improve my posture	1	2	3	4	5	6	7	8	9	10
Improve my stress management	1	2	3	4	5	6	7	8	9	10
Better moods/Improved outlook on life	1	2	3	4	5	6	7	8	9	10
Stop Smoking	1	2	3	4	5	6	7	8	9	10
Learn about wellness	1	2	3	4	5	6	7	8	9	10
Learn about wellness products that are right for me	1	2	3	4	5	6	7	8	9	10
Other_____	1	2	3	4	5	6	7	8	9	10

Which of the above would you say is the most important goal for you to achieve and why?

_____

_____

_____

Have you ever attempted to accomplish this goal in the past? Yes No

If yes, what happened and what prevented you from maintaining your results?

_____

Do you have any questions or comments?

_____

_____

_____

We look forward to Creating Wellness with you!

Lakeshore Chiropractic:
A Creating Wellness
Center

9745 Fall Creek Rd
Indianapolis, IN 46256
Tel (317)842.5100
Nate A. Blume, D.C.
Cole E. Blume, D.C.

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Your Wellness History – Health Profile

Date: _____

Name: _____ **DOB:** _____ **Age:** _____/ **Male Female**

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home # ( )_____ **Work: ( )**_____ **Cell: ( )**_____

Best time to contact: _____

Email address: _____ **Status: Single Married Divorced Widowed**

# of Children: _____ **Names/Age:** _____

Occupation: _____ **Employer Name/Address:** _____

Rate your health and wellness.

Place an '**X**' that denotes where you believe is your current level of wellness.
Place an '**O**' indicating where you would like your wellness to be.

YOUR HEALTH PROFILE

- What brings you into our office today?

Please briefly describe, including the impact if has had on your life. If you're only here for chiropractic wellness services please skip this part and go to "General History" on the next page.

Rate Severity (scale 1-10, 1being mild) When and how did this start? Are symptoms constant or intermittent?

_____

_____

_____

- Since the problem started it is; ___the same ___getting better ___ getting worse

What makes the problem worse?_____

_____

- What, if anything, makes the problem feel better?_____

_____

- Does this interfere with your; ___Leisure ___Work ___Sleep ___Sports ___Other

_____

- Have you seen other doctors for this condition? ___Chiropractor ___MD ___Other

Name/Address: _____ Date: _____

What was the diagnosis: _____

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GENERAL HISTORY

- Please list all medications you are taking, and why; (Prescription and non-prescription)

_____

_____

_____

- Have you had any surgeries and/or hospitalizations? ___Yes ___No

If yes, briefly explain:_____

_____

- Have you ever had any work related injuries? ___Yes ___No

If yes, briefly explain: _____

_____

- Have you ever had any slips, falls or auto accidents? ___Yes ___No

If yes, briefly explain:_____

_____

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

❑ Headaches	❑ Buzzing in ears	❑ Irritability	❑ Diarrhea
❑ Pins & needles in arms	❑ Ringing in ears	❑ Cold hands	❑ Cold sweats
❑ Pins & needles in legs	❑ Numbness in toes	❑ Cold feet	❑ Mood Swings
❑ Dizziness	❑ Depression	❑ Fever	❑ Loss of smell
❑ Numbness in fingers	❑ Constipation	❑ Urinary problem	❑ Loss of taste
❑ Fatigue	❑ Menstrual pain	❑ Fainting	❑ Back pain
❑ Sleeping problems	❑ Menstrual irregularity	❑ Eyes bothered by light	❑ Neck Pain
❑ Tension	❑ Hot flashes	❑ Stomach upset	❑ Stiff neck
❑ Ulcers			

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YOUR GOALS

➢ On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:
Scale =____ Occupational stress: _____
Scale =____ Personal stress: _____

➢ On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating_____ Exercise_____ Sleep_____ General Health_____ Wellness lifestyle_____

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals

Wellness Goals

Be Fit. *(Physical)*	Eat Right. *(Nutritional)*	Think Well. *(Psychological)*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check all that are relevant.

Do you:	Would you like to know more about:
❑ Water - Drink ½ your body weight in ounces	❑ Proper Nutrition and meal planning
❑ Exercise regularly	❑ Proper exercise routines and techniques
❑ Take vitamins or supplements	❑ How to deal with LifeStyle stress

Whom or what may we thank for referring you to our office? _____

Thank you for filling out this form.
It is your first step to Creating Wellness!

I consent to a professional and complete chiropractic examination, and to any radiographic examination that the doctor deems necessary. I understand that all fee's for services rendered are due at the time of service and cannot be deferred to a later date.

Signature: _____ Date: _____

Please return this form to our staff and someone will be right with you.

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Doctor-Patient Relationship in Chiropractic
Informed Consent

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions if you do not understand.

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic healthcare services.

ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of a Vertebral Subluxation Complex (VSC). When such VSCs are found, chiropractic adjustments and ancillary procedures may be given in order to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of your body.

DIAGNOSIS

Although Doctors of Chiropractic are experts in chiropractic diagnosis of the VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, and will gladly refer you to the appropriate medical specialist; however you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not give a chiropractic adjustment or health care if he/she is aware that such care may be contraindicated. The doctor will make every reasonable effort during their examination to screen for such contraindications; however it is the responsibility of the patient to make it known or to learn through health care procedures whether he/she is suffering from latent pathological defects, illnesses, or deformities that would otherwise not come to the attention of the Doctor of Chiropractic. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

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RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory, response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. The science of Chiropractic and Medicine may never be so exact as to provide definitive answers to all problems.

CERTIFICATION

I, _____, certify that I have read and understood the foregoing if I am accepted as a patient by Dr. Blume at Lakeshore Chiropractic, P.C., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Dated this ____ day of _____, 20____.

_____ _____

Patient Signature Signature of Witness

Consent of Treatment of Minor Child

I, _____ hereby authorize Dr. Blume and whomever he may designate as his assistant to administer chiropractic care as he deems necessary to my _____ (indicate relationship to child).

Dated this _____ day of _____, 20____.

_____ _____

Signature of parent Signature of witness

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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 THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Lakeshore Chiropractic (the "Practice"), in accordance with the federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state law, is committed to maintaining the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

How the Practice May Use and Disclose Your Protected Health Information

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

Treatment – To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care. For example, a chiropractor treating you for lower back pain may need to know and obtain the results of your latest physician examination or last treatment plan.

Payment – To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

Health Care Operations – To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

Other EXAMPLES OF HOW the Practice May Use Your Protected Health Information

Advice of Appointment and Services – The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

Directory/Sign-In Log – The Practice maintains a sign-in log at its reception desk for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Family/Friends – The Practice may disclose to a family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

•If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

•If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

Other Use & Disclosures WHICH MAY

BE PERMITTED OR REQUIRED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health Activities – The Practice may use and disclose PHI when required by law to provide information to a public health authority to prevent or control disease.

Abuse, Neglect or Domestic Violence – The Practice may use and disclose PHI when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm.

Health Oversight Activities – The Practice may use and disclose PHI when required by law to provide information in criminal investigations, disciplinary actions, or other activities relating to the community's health care system.

Judicial and Administrative Proceeding – The Practice may use and disclose PHI in response to a court order or a lawfully issued subpoena.

Law Enforcement Purposes – The Practice may use and disclose PHI, when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or if the Practice believes that your death was the result of criminal conduct.

Coroner or Medical Examiner – The Practice may use and disclose PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

Organ, Eye or Tissue Donation – The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs.

Research – The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities.

Avert a Threat to Health or Safety – The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

Specialized Government Functions – The Practice may use and disclose PHI when authorized by law with regard to certain military and veteran activity.

Workers' Compensation – The Practice may use and disclose PHI if you are involved in a Workers' Compensation claim to an individual or entity that is part of the Workers' Compensation system.

National Security and Intelligence Activities – The Practice may use and disclose PHI to authorized governmental officials with necessary intelligence information for national security activities.

Military and Veterans – The Practice may use and disclose PHI if you are a member of the armed forces, as required by the military command authorities.

Authorization

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Rights

You have the right to:

•Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

•Request special restrictions on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522(a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510(b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

•Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Inspect and copy your PHI as provided by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

•Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. •The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

•Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

Receive a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(iv)(F)) upon request to the Practice's Privacy Officer.

Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows:

Cole E. Blume, D.C., C.C.W.P.
Geist Crossing II
9745 Fall Creek Rd.
Indianapolis, IN 46256
317.842.5100

Practice's Requirements

The Practice:

Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

Is required to abide by the terms of this Privacy Notice.

Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

Will distribute any revised Privacy Notice to you prior to implementation.

Will not retaliate against you for filing a complaint.

Effective Date

This Notice is in effect as of 04/15/03.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

X_____ _____

Patient Date

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of my information to all my insurance companies.
- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I permit a copy of this authorization to be used in place of the original.
- I authorize my name to be used on the referral board.

Name (please print)_____

Signature:_____ Date:_____

Emergency Contact:

Name:_____

Cell Phone:_____ Home:_____

Work Phone:_____

Relationship:_____