Lueken Chiropractic
& Wellness Group

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Dr Chelsey Lueken
2606 E 350 S Suite 1
Lafayette, IN 47909
7656377303

____
Today's Date (MM/DD/YYYY)

Have you every consulted a Chiropractor before? Y N When? ____________

______________________________ Whom may we thank for referring you?

____________ (Date of Birth)

_______________ (SS#)

Gender M F

__________________________ (First Name)

________________________ (Last Name)

___________________________ (Middle)

____ (Address)

Marital Status: Single Married Divorced Widowed Separated

____________________________ (City) _________ (State) ___________ (Zip)

Spouses Name: _____________________________
Spouse Occupation:__________________________

______________________ (Cell Phone) _______________________ (Work Phone)

Child's Name and Age________________________
Child's Name and Age________________________
Child's Name and Age________________________
Child's Name and Age________________________

____ (Email)

Emergency Contact: ________________________
Phone: ________________________

____ (Occupation)

____ (Employer)

____ (Employer Address)

May we contact you at work if needed? Y N

Preferred method of contact:__Cell __Home __Email

____ (Primary Care Provider)

__________________________________ (PCP phone)

____ (Insurance Carrier)

__________________________________ (Policy Number)

____ (Insured's full name-first, middle, last)

____________________ (Birth Date MM/DD/YYYY)

Who carries this policy? Self Spouse Parent

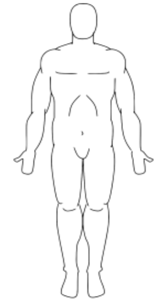
____ (Insured's Employer)

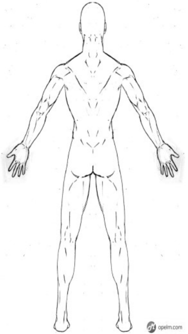
______________________________ (Phone)

______________________________________ (Address) _________________ City) _______ (State) ___________ (Zip)

Please describe your primary, secondary and additional complains in the appropriate boxes below:

Location: (where does it hurt? Circle the area(s) on the illustration.





Primary Complaint

The primary symptom that prompted me to seek care today is:

____
____
____

And are the result of

___an accident or injury

__work __Auto __Other

___a worsening long term problem

___an interest in wellness care

Onset (when did you first notice your symp-toms?)_____________________________

Prior Interventions: (what have you done to relieve the symptoms?)

__prescription medication __acupuncture
__over the counter drugs __chiropractic
__homeopathic remedies __massage
__physical therapy __ice
__surgery __heat

Secondary Complaint

The secondary symptom that prompted me to seek care today is:

____
____
____

And are the result of

___an accident or injury

__work __Auto __Other

___a worsening long term problem

___an interest in wellness care

Onset (when did you first notice your symp-toms?)_____________________________

Prior Interventions: (what have you done to relieve the symptoms?)

__prescription medication __acupuncture
__over the counter drugs __chiropractic
__homeopathic remedies __massage
__physical therapy __ice
__surgery __heat

Additional Complaint

The additional symptom that prompted me to seek care today is:

____
____
____

And are the result of

___an accident or injury

__work __Auto __Other

___a worsening long term problem

___an interest in wellness care

Onset (when did you first notice your symp-toms?)_____________________________

Prior Interventions: (what have you done to relieve the symptoms?)

__prescription medication __acupuncture
__over the counter drugs __chiropractic
__homeopathic remedies __massage
__physical therapy __ice
__surgery __heat

What else should Dr Chelsey know about your current condition? ____
____

How does your current condition interfere with your:
Work or career: ____
Recreational activities: ____
Household Responsibilities: ____
Personal Relationships: ____

Our office focuses on a holistic approach to your health. Please check each symptom below you current HAVE or HAD in the appropriate section

Musculoskeletal: (have)

__osteoporosis __arthritis __scoliosis
__neck pain __back pain __hip pain
__knee injuries __ankle injuries __shoulder pain
__TMJ pain __poor posture

(had)

__osteoporosis __arthritis __scoliosis
__neck pain __back pain __hip pain
__knee injuries __ankle injuries __shoulder pain
__TMJ pain __poor posture

Neurological: (have)

__anxiety __depression __headache
__dizziness __pins and needles __numbness
__blurred vision __ringing in ears __hearing loss

(had)

__anxiety __depression __headache
__dizziness __pins and needles __numbness
__ blurred vision __ringing in ears __hearing loss

Cardiovascular (have)

__high blood pressure __low blood pressure __angina
__poor circulation __excessive bruising __short breath

(had)

__high blood pressure __low blood pressure __angina
__poor circulation __excessive bruising __short breath

Digestive (have)

__constipation __diarrhea __heartburn
__food sensitivities __anorexia/bulimia

(had)

__constipation __diarrhea __heartburn
__food sensitivities __anorexia/bulimia

Respiratory (have)

__asthma __apnea __hay fever

(had)

__asthma __apnea __hay fever

Skin (have)

__acne __psoriasis __skin cancer
__hair loss __rash __eczema

had)

__acne __psoriasis __skin cancer
__hair loss __rash __eczema

Endocrine (have)

__thyroid issues __immune disorders __low energy
__swollen glands __frequent infection __hypoglycemia

(had)

__thyroid issues __immune disorders __low energy
__swollen glands __frequent infection __hypoglycemia

Genitourinary (have)

__kidney stones __infertility __bedwetting
__prostate issues __erectile dysfunction __PMS

(had)

__kidney stones __infertility __bedwetting
__prostate issues __erectile dysfunction __PMS

Constitutional (have)

__fainting __low libido __fatigue
__loss of appetite __sudden wt loss/gain __weakness

(had)

__fainting __low libido __fatigue
__loss of appetite __sudden wt loss/gain __weakness

Family History—some health issues are hereditary, tell Dr Chelsey about the health of your immediate family members

Relative	**Age (if living)**	**State of health**	**Illnesses**	**Age of Death and cause**
Mother	__________	____________	_____________________________	______________________________
Father	__________	____________	_____________________________	______________________________
Sister	__________	____________	_____________________________	______________________________
Sister 2	__________	____________	_____________________________	______________________________
Brother	__________	____________	_____________________________	______________________________
Brother 2	__________	____________	_____________________________	______________________________
Spouse	__________	____________	_____________________________	______________________________

Social History– tell Dr Chelsey about your health habits and stress levels

Alcohol use O Daily O Weekly How much? ____

Coffee use O Daily O Weekly How much ? ____

Tobacco use O Daily O Weekly How much? ____

Exercising O Daily O Weekly How much? ____

Pain relievers O Daily O Weekly How much? ____

Soft drinks O Daily O Weekly How much? ____

Water intake O Daily O Weekly How much? ____

Hobbies: ____

Please rate your level of stress 0-10 and give a brief description why you rated it what you did ________________________

____

What is the major stressor in your life? ________________ How many hours do you average per night? _______________

What is the type and approximate age of your mattress and pillow? ____

Describe your typical eating habits: O skip breakfast O two meals a day O Three meals a day O snacking between meals

What could be the most significant thing you could do to improve your health? ___________________________________

____

In addition to the main reason for your visit today, what additional health goals do you have?_________________________

____

____

(Doctor's signature)

Activities of Daily Living– how is this condition interfere with your life and ability to function?

	0	1	2	3	4	5
Sitting————————————-	O	O	O	O	O	O
Rising out of chair——————O		O	O	O	O	O
Standing———————————-	O	O	O	O	O	O
Walking————————————	O	O	O	O	O	O
Lying down—————————-	O	O	O	O	O	O
Bending over—————————-	O	O	O	O	O	O
Climbing stairs—————————	O	O	O	O	O	O
Using a computer——————-	O	O	O	O	O	O
Getting in/out of car————	O	O	O	O	O	O
Driving a car—————————-	O	O	O	O	O	O
Caring for family——————--	O	O	O	O	O	O

	0	1	2	3	4	5
Shopping——————————	O	O	O	O	O	O
Household chores——————	O	O	O	O	O	O
Lifting objects————————-	O	O	O	O	O	O
Reaching overhead —————	O	O	O	O	O	O
Showering or bathing————	O	O	O	O	O	O
Dressing ————————————	O	O	O	O	O	O
Love life————————————	O	O	O	O	O	O
Sleep——————————————--	O	O	O	O	O	O
Concentrating————————--	O	O	O	O	O	O
Exercising———————————--	O	O	O	O	O	O
Yard work———————————--	O	O	O	O	O	O

Females

Are you O Cycling monthly O Perimenopausal O Menopausal

Date of first day of last menses____________________

Are you currently pregnant? Y N How far along are you? _________weeks Due date_______________

Are you currently breastfeeding? Y N

Are you currently using birth control? Y N What kind? ____

Do you :

Experience painful periods?	Y N		Have irregular cycles?	Y N	
Have heavy/clotty periods?	Y N		Have spotting between cycles?	Y N	
Have painful or crampy periods?	Y N		Experience infertility?	Y N	
Perform monthly breast exams?	Y N		Have annual mammograms?	Y N	
Miscarried?	Y N				

When did you miscarry and what was the reason you were told for the occurrence? ____

____

Notice of Privacy Policy

_______I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration or maintenance of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a sep arate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_______I may request a copy of the privacy policy and understand it describes how my personal health information is pro tected and released on my behalf for seeking reimbursement from any involved third parties.

_______I grant my permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office

_______I acknowledge that any insurance I have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive

_______To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern

____ ____

(print name) (signature)

____

Doctor’s signature

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

<u>The nature of chiropractic treatment:</u> The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

<u>Possible Risks:</u> As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

<u>Probability of risks occurring:</u> The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

<u>Other treatment options which could be considered</u> may include the following:

Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

<u>Risks of remaining untreated:</u> Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

<u>Unusual risks:</u> I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

______________________	______________________	__________
Printed Name	**Signature**	**Date**

____

(doctor’s signature)