Special Instructions for Filling Out Forms:

1) Please fill out completely. We need this to fulfill documentation requirements and to accurately assess your health and condition.
2) Anything that does not apply, draw a line through it.
3) If you need help, ask the receptionist. Call us if we have faxed or emailed and you need help.
4) Please bring to the front desk when finished. If we faxed or emailed, bring filled-out forms to your appointment.
5) We will need a copy of your insurance card if applicable.

Lash Chiropractic Center: Donald Lash, D.C./Mark Hogue, D.C.
100 North Gamble Street Shelby, Ohio 44875
419-342-2931(phone)~~419-347-7096(fax)

Date: _____

Confidential Patient Information

Patients Name: _____
Address: _____
City: _____ Zip: _____
SS#: _____
Date of Birth: _____
Occupation: _____
How did you find out about our office? _____

Chief Complaint: _____
Home Phone: _____
Cell Phone: _____
Email: _____
Marital Status: M S W D Children names and ages:
Employer and work phone: _____
Pets:

Person to contact in case of emergency (Name and Phone): _____
Have you ever been under Chiropractic Care? Y N If so, with whom? _____ Nutrition care? Y N _____
Have you had any X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____
What serious accidents or injuries have you had?: _____
What operations have you had? _____ When? _____
Serious Illness: _____ When? _____
Infectious Diseases: _____ When? _____
Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N
What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin ____ Cholesterol Meds ____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart attack/stroke	Y N Heart surgery	Y N Heart Murmur	Y N Congenital Heart Defect
Y N Mitral Valve Prolapse	Y N Artificial Valves	Y N Alcohol/Drug Abuse	Y N Venereal Disease
Y N Hepatitis	Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent neck pain	Y N Emphysema	Y N Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic fever	Y N Headaches
Y N Kidney problems	Y N Ulcers/Colitis	Y N Sinus problems	Y N Fainting\ Seizure\ Epilepsy
Y N Arthritis	Y N Artificial bones/joints	Y N Lower back problems	
Y N Chemotherapy/Radiation	Y N Difficulty Breathing	Y N Tuberculosis	Y N Difficulty Breathing
Y N Asthma	Y N Diabetes		

Who is your medical physician? _____

Chief Concerns: 1) _____
2) _____
3) _____
4) _____

Confidential Patient Information and Case History Continued Name_____Date___/___/___

Please list any other serious medical condition(s) you have or ever had:_____

Please list anything that you are allergic to :_____

List any past serious accidents or falls with dates:_____

Family Health History:_____

Do You: Take supplements or Vitamins? ◯Yes ◯No / Exercise? ◯Yes ◯No/ Are you on a special diet? ◯Yes ◯No Since:__/__/__
Do you smoke? ◯No ◯Yes/ How much? _____How long?_____
Are you wearing: ◯Heel lifts ◯Sole lifts ◯Inner soles ◯Arch supports Do you wear your seatbelt? ◯Yes◯No
What is the age of your mattress?_____Is it comfortable? ◯Yes ◯No

For Women: Are you taking birth control? ◯Yes ◯No Are you pregnant? ◯Yes /How long?_____◯No Nursing? ◯Yes◯No

Review of Systems**(Leave this section blank. The doctor will review this with you):**

1) Constitutional: Vital signs: 1) sitting or standing blood pressure____, 2) supine blood pressure____, 3) pulse rate and Regularity____4) respiration____, 5) temperature____, 6) height____, 7) weight____

2) Head, Face, neck

3) Eyes, ears, nose, mouth, throat
Teeth missing:
Teeth with fillings and type:

4) Nervous/psychiatric

5) Endocrine:

6) Cardiovascular:

7) Lymphatic:

8) Respiratory:

9) Gastrointestinal:

10) Urinary/ Reproductive:

11) Integementary(skin):

12) Musculoskeletal:

A
A
S
D

SYMPTOM SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ☐ Female ☐

Pulse: Recumbent _____ Standing _____ Vegetarian: Yes ☐ No ☐

Blood pressure: Recumbent ___/___ Standing ___/___ Ragland's Test is Positive ☐

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurred once or twice last 6 months).
○ ● ○ MODERATE symptoms (occurred once or twice last month).
○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1 2 3	
		GROUP 1
1	○ ○ ○	Acid foods upset
2	○ ○ ○	Get chilled often
3	○ ○ ○	"Lump" in throat
4	○ ○ ○	Dry mouth-eyes-nose
5	○ ○ ○	Pulse speeds after meal
6	○ ○ ○	Keyed up - fail to calm
7	○ ○ ○	Cut heals slowly
8	○ ○ ○	Gag easily
9	○ ○ ○	Unable to relax; startles easily
10	○ ○ ○	Extremities cold, clammy
11	○ ○ ○	Strong light irritates
12	○ ○ ○	Urine amount reduced
13	○ ○ ○	Heart pounds after retiring
14	○ ○ ○	"Nervous" stomach
15	○ ○ ○	Appetite reduced
16	○ ○ ○	Cold sweats often
17	○ ○ ○	Fever easily raised
18	○ ○ ○	Neuralgia-like pains
19	○ ○ ○	Staring, blinks little
20	○ ○ ○	Sour stomach often
		GROUP 2
21	○ ○ ○	Joint stiffness on arising
22	○ ○ ○	Muscle-leg-toe cramps at night
23	○ ○ ○	"Butterfly" stomach, cramps
24	○ ○ ○	Eyes or nose watery
25	○ ○ ○	Eyes blink often
26	○ ○ ○	Eyelids swollen, puffy
27	○ ○ ○	Indigestion soon after meals
28	○ ○ ○	Always seems hungry; feels "lightheaded" often
29	○ ○ ○	Digestion rapid
30	○ ○ ○	Vomiting frequent
31	○ ○ ○	Hoarseness frequent
32	○ ○ ○	Breathing irregular
33	○ ○ ○	Pulse slow; feels "irregular"
34	○ ○ ○	Gagging reflex slow
35	○ ○ ○	Difficulty swallowing
36	○ ○ ○	Constipation, diarrhea alternating
37	○ ○ ○	"Slow starter"
38	○ ○ ○	Get "chilled" infrequently
39	○ ○ ○	Perspire easily
40	○ ○ ○	Circulation poor, sensitive to cold
41	○ ○ ○	Subject to colds, asthma, bronchitis
		GROUP 3
42	○ ○ ○	Eat when nervous
43	○ ○ ○	Excessive appetite
44	○ ○ ○	Hungry between meals
45	○ ○ ○	Irritable before meals
46	○ ○ ○	Get "shaky" if hungry
47	○ ○ ○	Fatigue, eating relieves
48	○ ○ ○	"Lightheaded" if meals delayed
49	○ ○ ○	Heart palpitates if meals missed or delayed
50	○ ○ ○	Afternoon headaches
51	○ ○ ○	Overeating sweets upsets

	1 2 3	
52	○ ○ ○	Awaken after few hours sleep - hard to get back to sleep
53	○ ○ ○	Crave candy or coffee in afternoons
54	○ ○ ○	Moods of depression - "blues" or melancholy
55	○ ○ ○	Abnormal craving for sweets or snacks
		GROUP 4
56	○ ○ ○	Hands and feet go to sleep easily, numbness
57	○ ○ ○	Sigh frequently, "air hunger"
58	○ ○ ○	Aware of "breathing heavily"
59	○ ○ ○	High altitude discomfort
60	○ ○ ○	Opens windows in closed rooms
61	○ ○ ○	Susceptible to colds and fevers
62	○ ○ ○	Afternoon "yawner"
63	○ ○ ○	Get "drowsy" often
64	○ ○ ○	Swollen ankles, worse at night
65	○ ○ ○	Muscle cramps, worse during exercise; get "charley horses"
66	○ ○ ○	Shortness of breath on exertion
67	○ ○ ○	Dull pain in chest or radiating into left arm, worse on exertion
68	○ ○ ○	Bruise easily, "black and blue" spots
69	○ ○ ○	Tendency to anemia
70	○ ○ ○	"Nose bleeds" frequent
71	○ ○ ○	Noises in head, or "ringing in ears"
72	○ ○ ○	Tension under the breastbone, or feeling of "tightness", worse on exertion
		GROUP 5
73	○ ○ ○	Dizziness
74	○ ○ ○	Dry skin
75	○ ○ ○	Burning feet
76	○ ○ ○	Blurred vision
77	○ ○ ○	Itching skin and feet
78	○ ○ ○	Excessive falling hair
79	○ ○ ○	Frequent skin rashes
80	○ ○ ○	Bitter, metallic taste in mouth in mornings
81	○ ○ ○	Bowel movements painful or difficult
82	○ ○ ○	Worrier, feels insecure
83	○ ○ ○	Feeling queasy; headache over eyes
84	○ ○ ○	Greasy foods upset
85	○ ○ ○	Stools light colored
86	○ ○ ○	Skin peels on foot soles
87	○ ○ ○	Pain between shoulder blades
88	○ ○ ○	Use laxatives
89	○ ○ ○	Stools alternate from soft to watery
90	○ ○ ○	History of gallbladder attacks or gallstones
91	○ ○ ○	Sneezing attacks
92	○ ○ ○	Dreaming, nightmare type bad dreams
93	○ ○ ○	Bad breath (halitosis)
94	○ ○ ○	Milk products cause distress
95	○ ○ ○	Sensitive to hot weather
96	○ ○ ○	Burning or itching anus
97	○ ○ ○	Crave sweets
		GROUP 6
98	○ ○ ○	Loss of taste for meat
99	○ ○ ○	Lower bowel gas several hours after eating
100	○ ○ ○	Burning stomach sensations, eating relieves
101	○ ○ ○	Coated tongue
102	○ ○ ○	Pass large amounts of foul-smelling gas
103	○ ○ ○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○ ○ ○	Mucous colitis or "irritable bowel"
105	○ ○ ○	Gas shortly after eating
106	○ ○ ○	Stomach "bloating" after eating

	1	2	3	
				GROUP 7A
107	O	O	O	Insomnia
108	O	O	O	Nervousness
109	O	O	O	Can't gain weight
110	O	O	O	Intolerance to heat
111	O	O	O	Highly emotional
112	O	O	O	Flush easily
113	O	O	O	Night sweats
114	O	O	O	Thin, moist skin
115	O	O	O	Inward trembling
116	O	O	O	Heart palpitates
117	O	O	O	Increased appetite without weight gain
118	O	O	O	Pulse fast at rest
119	O	O	O	Eyelids and face twitch
120	O	O	O	Irritable and restless
121	O	O	O	Can't work under pressure
				GROUP 7B
122	O	O	O	Increase in weight
123	O	O	O	Decrease in appetite
124	O	O	O	Fatigue easily
125	O	O	O	Ringing in ears
126	O	O	O	Sleepy during day
127	O	O	O	Sensitive to cold
128	O	O	O	Dry or scaly skin
129	O	O	O	Constipation
130	O	O	O	Mental sluggishness
131	O	O	O	Hair coarse, falls out
132	O	O	O	Headaches upon arising, wear off during day
133	O	O	O	Slow pulse, below 65
134	O	O	O	Frequency of urination
135	O	O	O	Impaired hearing
136	O	O	O	Reduced initiative
				GROUP 7C
137	O	O	O	Failing memory
138	O	O	O	Low blood pressure
139	O	O	O	Increased sex drive
140	O	O	O	Headaches, "splitting or rending" type
141	O	O	O	Decreased sugar tolerance
				GROUP 7D
142	O	O	O	Abnormal thirst
143	O	O	O	Bloating of abdomen
144	O	O	O	Weight gain around hips or waist
145	O	O	O	Sex drive reduced or lacking
146	O	O	O	Tendency to ulcers, colitis
147	O	O	O	Increased sugar tolerance
148	O	O	O	Women: menstrual disorders
149	O	O	O	Young girls: lack of menstrual function
				GROUP 7E
150	O	O	O	Dizziness
151	O	O	O	Headaches
152	O	O	O	Hot flashes
153	O	O	O	Increased blood pressure
154	O	O	O	Hair growth on face or body (female)
155	O	O	O	Sugar in urine (not diabetes)
156	O	O	O	Masculine tendencies (female)
				GROUP 7F
157	O	O	O	Weakness, dizziness
158	O	O	O	Chronic fatigue
159	O	O	O	Low blood pressure
160	O	O	O	Nails weak, ridged
161	O	O	O	Tendency to hives
162	O	O	O	Arthritic tendencies
163	O	O	O	Perspiration increase
164	O	O	O	Bowel disorders
165	O	O	O	Poor circulation
166	O	O	O	Swollen ankles
167	O	O	O	Crave salt
168	O	O	O	Brown spots or bronzing of skin
169	O	O	O	Allergies - tendency to asthma

	1	2	3	
170	O	O	O	Weakness after colds, influenza
171	O	O	O	Exhaustion - muscular and nervous
172	O	O	O	Respiratory disorders
				GROUP 8
173	O	O	O	Apprehension
174	O	O	O	Irritability
175	O	O	O	Morbid fears
176	O	O	O	Never seems to get well
177	O	O	O	Forgetfulness
178	O	O	O	Indigestion
179	O	O	O	Poor appetite
180	O	O	O	Craving for sweets
181	O	O	O	Muscular soreness
182	O	O	O	Depression; feelings of dread
183	O	O	O	Noise sensitivity
184	O	O	O	Acoustic hallucinations
185	O	O	O	Tendency to cry without reason
186	O	O	O	Hair is coarse and/or thinning
187	O	O	O	Weakness
188	O	O	O	Fatigue
189	O	O	O	Skin sensitive to touch
190	O	O	O	Tendency toward hives
191	O	O	O	Nervousness
192	O	O	O	Headache
193	O	O	O	Insomnia
194	O	O	O	Anxiety
195	O	O	O	Anorexia
196	O	O	O	Inability to concentrate; confusion
197	O	O	O	Frequent stuffy nose; sinus infections
198	O	O	O	Allergy to some foods
199	O	O	O	Loose joints
				FEMALE ONLY
200	O	O	O	Very easily fatigued
201	O	O	O	Premenstrual tension
202	O	O	O	Painful menses
203	O	O	O	Depressed feelings before menstruation
204	O	O	O	Menstruation excessive and prolonged
205	O	O	O	Painful breasts
206	O	O	O	Menstruate too frequently
207	O	O	O	Vaginal discharge
208			O	Hysterectomy / ovaries removed
209	O	O	O	Menopausal hot flashes
210	O	O	O	Menses scanty or missed
211	O	O	O	Acne, worse at menses
212	O	O	O	Depression of long standing
				MALE ONLY
213	O	O	O	Prostate trouble
214	O	O	O	Urination difficult or dribbling
215	O	O	O	Night urination frequent
216	O	O	O	Depression
217	O	O	O	Pain on inside of legs or heels
218	O	O	O	Feeling of incomplete bowel evacuation
219	O	O	O	Lack of energy
220	O	O	O	Migrating aches and pains
221	O	O	O	Tire too easily
222	O	O	O	Avoids activity
223	O	O	O	Leg nervousness at night
224	O	O	O	Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

SUBSTANCE SURVEY FORM

NAME:_____ **DATE:**_____

Please list any prescription medications you are currently taking or have taken in the last year.

Medications	**Diagnosis**

Please list any over-the-counter medications you are currently taking or have taken in the past year.

Product	**Symptom**	**Quantity & Frequency Taken**

Please list any vitamins, supplements, herbs or homeopathic medicines you are currently taking or have taken in the past year. (use other side of paper if needed)

Product	**Amount Taken Daily**	**How Long Taken**

Check the following items which apply to you and indicate the amount used:

- ◯ COFFEE _____
- ◯ TEA _____
- ◯ SOFT DRINKS _____
- ◯ ARTIFICIAL SWEETNERS _____
- ◯ ANTACIDS _____
- ◯ LAXATIVES _____
- ◯ CANDY _____
- ◯ ICE CREAM _____
- ◯ ALCOHOL _____
- ◯ CIGARETTES _____
- ◯ OTHER TOBACCO PRODUCTS _____

How many desserts do you have in an Average week? _____

Other information:_____

SURVEY OF YOUR OVERALL HEALTH OF YOUR BODY SYSTEMS

Patient Name:_____ **Date Today:**_____

HEADACHES
__Base of Skull (Back)
__Side of Head (Temples)
__Frontal (Above Eyes)
__Top of Head
__Entire Head
__Migraines
__Cluster
__Other_____

EARS
__Noise (Ring/Hiss/Pound)
__Plugged
__Popping
__Ear Ache
__Draining
__Itching
__Hearing Loss
__Dizziness/Vertigo
__Excessive Earwax
__Other_____

EYES
__Burn
__Tear
__Ache
__Red
__Dry
__Eye Film
__Crust in Morning
__Itchy Eyes
__Bouts of Blurriness
__Floaters
__Spots
__Tired
__Puffy
__Styes
__Twitching Around Eyes
__Dark Circles
__Light Bothers Eyes
__Nearsighted
__Farsighted
__Other_____

SINUS
__Nose Bleeds
__Dry
__Drain
__Stuffy/Plugged Up
__Sneeze Frequently
__Smell Loss
__Taste Loss
__Post Nasal Drip: (circle color)
WHITE/YELLOW/GREEN
GREY/BROWN/BLOODY/
CLEAR
__Other_____

MOUTH/THROAT/ IMMUNE
__Blisters
__Canker Sores
__Bad Breath
__Bleeding Gums
__Receding Gums
__Teeth Health Problems
__Dry Mouth
__Swelling of Glands
__Difficulty Swallowing
__Sore Throat
__Hoarseness
__Fever
__Chills
__Cold/Sweaty hands or feet
__Cough (dry or productive?)
__Environmental Allergies
__Upper Respiratory Infection
__Frequent Colds/Flu
__Chronic Bronchitis
__Other_____

CHEST
__Tension
__Tight
__Pressure
__Heaviness
__Congestion
__Chest Pain
__Sternal Pain
__Sharp Heart Pain
__Palpitations-Heart Skip/Flutter
__Heart racing
__Heart Slow Down
__Mitral Valve Prolapse
__Murmur
__Other_____

SHORTNESS OF BREATH
__Constant
__Upon Exertion
__Wheeze
__Air Hunger
__Asthma
__Frequent Sighs
__Emphysema
__Other_____

STOMACH
__Heartburn
__Indigestion
__Stomach Aches
__Stomach Cramps
__Nausea/Queasy
__Bloat after Eating
__Gas/Flatulence
__Belching
__Ulcer
__Hiatal Hernia
__Other_____

BOWELS
__How many Bowel Movements/Day
__Regular
__Incomplete
__Skip days____per (week/month)
__Sluggish bowels every ____ days
__Cramps in Abdomen
__Taking Laxatives
__Using Suppositories
__Enemas
__Colonics
__Bulky
__Pain with Bowel Movements
__Irritable Bowel Syndrome
__Chrons
__Colitis
__Other_____

FECAL CONSISTENCY
Color of Feces-LIGHT or DARK
__Normal
__Soft
__Hard
__Pebbles
__Dry
__Ribbon-Like
__Mucous
__Diarrhea
__Constipation
__Other_____

HEMORRHOIDS
__Swollen
__Burning
__Blood
__Distended
__Itchy
__Stingy
__Achy

URINATION
__Times per Day (frequency)
__Urinate at Night__X Per Night?
__Urgency
__Burning
__Pain
__Order
__Spasm
__Leakage
__Urinary Tract Infection
__Incontinence
__Kidney Troubles
__Other_____

ENERGY
__Low
__Variable
__Normal
__High
__Slow to Start in the Morning
__Low Energy After Meals
__Energy Crash__AM__PM
__Other_____

SLEEP
__Quality (poor/fair/good/great)
__Hours in Bed
__Hours Asleep
__Difficulty Falling Asleep
__Difficulty Staying Asleep
__Interrupted__X per Night?
__Crave Sleep During Day
__Awaken Suddenly (jolt)
__Don't Remember Dreams
__Nightmares
__Night Sweats
__Restlessness
__Sleep Apnea
__Other_____

EMOTIONS
__Stressed
__Sad
__Grief
__Depression
__Moodiness
__Frustrated
__Irritable
__Angry
__Worrisome
__Nervous
__Anxiety
__Panic
__Cry
__Fear
__Shame
__Other_____

APPETITE/DIET
__Low Appetite
__Normal Appetite
__High Appetite
__Starch (pasta/bread/potatoes/rice)
__Sweets
__Chocolate
__Coffee__cup/day
__Caffeinated Tea__cups/day
__Beer__per week
__Wine__per week
__Juice__per week
__Soda__per week
__Artificial Sweeteners
__Eat a lot of Spicy Foods
__Ice Cream

EXERCISE
__Cardiovascular__X per week
__Weight Training__X per week

MEMORY
__Forget Names
__Forget Numbers
__Forget Words
__Forget Actions
__Difficulty Concentrating
__Other_____

LIBIDO/SEXUALITY
__Flat
__Low
__Normal
__Erectile Dysfunction (men)
__Orgasm Quality (poor/fair/good)
__Other_____

SKIN/HAIR/NAILS
__Skin Rash
__Acne
__Dry Skin
__Itchy Skin
__Patches: skin looks different
__Cellulite
__Nails
__Hair Loss
__Limp hair
__Other_____

CRAMPS/ACHES/ RESTLESS
__Cramps (legs/feet/arms/hands)
__Aches (legs/feet/arms/hands)
__Restless (legs/feet/arms/hands)
__Other_____

PAIN/STIFFNESS/ SWELLING/ NUMBNESS/ TINGLING
__Facial
__Neck
__Trapezeus
__Upper back
__Shoulders
__Arms
__Elbows
__Wrist
__Hand
__Mid Back
__Low back
__Sacral Iliac
__Hips
__Buttocks
__Legs
__Sciatica
__Knees
__Ankles
__Feet
__Other_____

FOR MEN ONLY (PROSTATE)
__Burn
__Achiness
__Pain
__Restriction
__Dribbling
__Emission
__Swelling
__Other_____

LIST YOUR PRIMARY CONCERNS :
_____
_____
_____

MENSES (women only)
Last Menstrual Period_____
Length of Menses_____
__Regular
__Irregular
__Early (less than 28 days)
__Late (more than 28 days)
__Skip
__Birth Control Pills
__Flow (Heavy/Moderate/Light)
__Clotting/Spotting
__Cramps (Mild/Moderate/Severe)
__Low Abdominal Puffiness
__Fluid Retention Face
__Fluid Retention Hands
__Fluid Retention Feet
__Tired During Cycle
__Acne (Pre/Post)
__Mood Swings/Irritable/Depressed
__Breast Tenderness Near Cycle
__Other_____

BREASTS (women only)
__Breast Tender Constant
__Breast Feeding
__Fibrosis
__Lump
__Discharge
__Prosthesis
__Augmentation
__Reduction Surgery
__Pathology
__Other_____

VAGINA (women only)
__Burn
__Itch
__Dry
__Pain
__Blood
__Discharge
-Clear
-White
-Yellow
-Green
-Brown
-Odor
__Other_____

MENOPAUSE (women only)
__Natural
__Surgical (partial/complete)
__Hormones
__Patch
__Hot Flashes
__Skin Crawling
__Cherry Hemangiomas
__Facial hair
__Hair Growing Up Toward Belly Button
__Dark Nipple Hair
__Other_____

FOR DOCTOR'S USE
__Fremular Cyst
__Cracks in Tongue
__Allergy Patches Tongue
__Geographic Tongue
__Red Spots Tongue
__Swollen Tongue
__Color Tongue_____
__Dark Veins Tongue
__Coated Tongue (mild/mod/severe)
__Ear Creases (Rt/Lt)
(mild/moderate/severe)
Weight_____
Height_____
Pulse_____
BP_____
Saliva PH_____
Urine PH_____
Allergies_____
Current
Meds:_____
_____
_____

Lash Chiropractic Center: Mark Hogue, D.C./Donald Lash, D.C.
100 North Gamble Street Shelby, Ohio 44875
419-342-2931(phone)◯419-347-7096(fax)

Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPAA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

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Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, 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 problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Lash Chiropractic Center, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

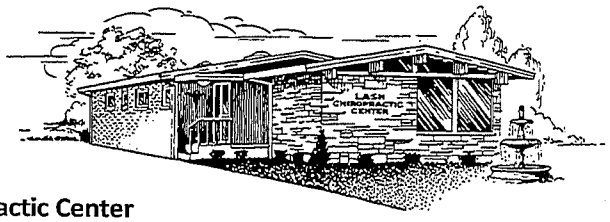
I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Lash Chiropractic Center

DR. DONALD B. LASH • DR. MARK W. HOGUE
100 North Gamble Street • Shelby, Ohio 44875
Phone (419) 342-2931 • Fax (419) 347-7096



Financial Policy for Lash Chiropractic Center

Our fees are payable by you at the time of service. Deductibles and co-pays must be paid at the time of service. We only allow charging IF and ONLY IF insurance has been established and we are certain that they will pay. Not all insurances cover chiropractic. Each insurance company and its deductible and co-pay amounts vary, as well as their reimbursement amount. We will electronically bill your insurance company. In the event that your insurance company reimburses us, we will refund you promptly.

Health insurance is in a major state of change due to recent events such as the Federal Affordable Care Act. Therefore, it is our expectation that YOU check your own insurance coverage and know whether it covers chiropractic, what percentage, and the number of visits. Dr. Lash and Dr. Hogue do not make treatment recommendations based on what insurance covers, rather treatment recommendations are based on what we have assessed will best help you regain your health.

It is required that you pay for your initial consultation at the time of service. Once insurance has been established, which takes approximately 4-6 weeks (at most), then your payment will be based on your individual insurance.
Nutritional visits and supplements are not covered by insurance and must be paid by you at the time of service.
Neuroemotional technique (NET) is not covered by any insurance.

First time Chiropractic patient or reactivated former patient examination: (This includes history, appropriate examination, and adjustment)	$70.00
Chiropractic manipulative therapy office visit:	$45.00
First time Nutritional patient (includes nutrition response testing, Bioimpedience analysis (BIA), heart rate variability (HRV), and history)	$100.00
Nutrition office visit:	$45.00

CASH ONLY SERVICES

Job and Sports physical	$45.00
Established patients	$23.00
First-time Neuroemotional Technique (NET) patient (includes history, Examination, and neuroemotional technique)	$70.00
Neuroemotional Technique office visit (30 minutes):	$45.00

Even if you schedule NET and Nutrition on the same day, they are considered two **separate** visits and you will be charged accordingly.

We accept the following forms of payment: Cash, VISA, MC, Discover, AmEx, Debit, Personal Check

By signing below, I understand the above policy, fees, and that I am responsible for payment (full amount) of the first visit and following visits until insurance has been established.

Sign name: _____ Date: _____

Print name: _____

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PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF NUTRITION RESPONSE TESTING™

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at the Lash Chiropractic Center to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural organ responses can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date:_____

Print Name: _____

Address: _____

City _____ State_____ Zip _____

Phone: (____) _____ - _____

Signed: _____

(If minor, signature of parent or guardian required)

Witness: _____