The Chiropractic Transformation Center

Welcome New Practice Member!

Today's Date_____

Personal Data

Name _____ Date of Birth _____ Gender: M F

Home Phone (____)_____ Email address_____

Cell Phone (____)_____Work Phone(____)_____**Circle your preferred phone number.**

Home Address _____ City_____ State_____ Zip_____

Marital Status: S M D W L/W Name of Spouse _____

Parents' names (if you are under 18) _____

Occupation _____ Employer _____

Business Address _____ City _____ State_____ Zip_____

Business Phone (_____) _____

Whom may we thank for referring you? _____

Reason for Seeking Chiropractic Care

What concerns do you feel I can address for you?_____

_____

Is this concern affecting any of the activities below? (Please circle)

Work:	Yes	No	Recreation/play:	Yes	No	Sleep:	Yes	No
Social Life:	Yes	No	Walking:	Yes	No	Sitting:	Yes	No
Exercise:	Yes	No	Eating:	Yes	No	Love life:	Yes	No

Other Data

Have you ever received Chiropractic care? Y N With Whom? _____

Date of last visit: _____ Why did you stop care? _____

Do you have a family medical doctor? Y N Who? _____

Do you consult him/her regularly? Y N If so, why? _____

Date of last medical consultation and result: _____

For Women: Date of last menstrual period: _____

Dr. Casey LaPierre ~ Location: 63A Elm Street Topsham ME 04086 ~Phone: 207-502-4119

Email: chirotransformation@gmail.com

Health, Wellness and Chiropractic Care

Throughout life, stresses and traumatic events can damage the spine and nerve system. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature. Understanding the PHYSICAL, CHEMICAL, or EMOTIONAL stresses that have acted upon your spine and nerve system assists us in serving you. Please answer the following questions as accurately and completely as possible.

History of Physical Stresses (Birth to Present)

Birth Stress

Research indicates that the birth process can cause trauma to a baby's spine and nerve system. Please indicate to the best of your recollection how you were birthed:

Was your birth: (check all that apply)

□ drug induced □ C section □ breech □ natural □ forceps

□ prolonged □ cord around neck □ at home □ in hospital □ suction

General Physical Trauma

Most trauma occurs in the early years (between birth and age 18-21). It is during those years that your spine and nerve system is growing and most impressionable. The information below will help us to see the types of stresses that you have been subjected to.

Have you had any accidents related to the following: (check all that apply and give dates)

□automobile (even as a passenger) □ motorcycle □ bicycle □ sports □ other _____

If yes, please explain how and when: _____

_____

Have you ever injured your spine (neck, head, back, hips)? □yes□ no

If yes, please explain how and when: _____

_____

Have you ever broken any bones or sprained any part of your body? □yes□ no

If yes, please explain how and when: _____

_____

Have you ever been hospitalized? □yes□ no

If yes, please explain how and when: _____

_____

Dr. Casey LaPierre ~ Location: 63A Elm Street Topsham ME 04086 ~Phone: 207-502-4119

Email: chirotransformation@gmail.com

History of Chemical Stresses

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed in the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Have you been vaccinated?	□ yes	□ no		
Do you or have you ever taken?	□ prescription drugs	□ over the counter drugs	□ recreational drugs	
Have you been exposed to?	□ chemicals	□ fumes	□ dust	□ smoke
Do you consume?	□ alcohol	□ coffee/caffeine	□ tobacco	

List Current Medications: _____

Any Medications Previously taken for more than 6 months?_____

History of Emotional Stresses

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below. (Please circle)

Childhood trauma	Yes No	Loss of loved one	Yes No	Relationships	Yes No	Family	Yes No
Work or School	Yes No	Divorce/separation	Yes No	Financial	Yes No	Abuse	Yes No
Lifestyle change	Yes No	Parents' divorce	Yes No	Illness	Yes No	Other	Yes No

Quality of Life

How do you grade your physical health?	□ Good	□ Fair	□ Poor
How do you grade your emotional/mental health?	□ Good	□ Fair	□ Poor
How do you rate your overall "quality of life"?	□ Good	□ Fair	□ Poor

Dr. Casey LaPierre ~ Location: 63A Elm Street Topsham ME 04086 ~Phone: 207-502-4119

Email: chirotransformation@gmail.com

Financial Information

Payment in full is expected in all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.
****The cash fee for a new patient is $150.00, which includes the first consult, a chiropractic exam, a report of findings, and the first adjustment****

Signature _____ Today's Date _____

Appointment Reminders and Health Care Information Authorization

The following office procedures allow Dr. LaPierre to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including postcards) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- We would like to be able to refer others to speak with you about your experience.

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Dr. LaPierre's office.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Dr. LaPierre is very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Dr. LaPierre's *Notice of Privacy Practices for Protected Health Information.* Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

_____ _____
Patient name printed Date

_____ _____
Patient Signature CC representative

Dr. Casey LaPierre ~ Location: 63A Elm Street Topsham ME 04086 ~Phone: 207-502-4119

Email: chirotransformation@gmail.com

Terms and Consent to Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. The objective of chiropractic health care in this office is ***to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations***.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.
I, _____ have read and fully understand the above (print name).

Outcomes and options relative to care have been discussed and noted. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

Dr. Casey LaPierre ~ Location: 63A Elm Street Topsham ME 04086 ~Phone: 207-502-4119

Email: chirotransformation@gmail.com

Electronic Health Records Intake Form

First Name:_____ **Last Name**:_____

Mailing Address: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

□ **I choose to decline receipt of my clinical summary after every visit.**

Patient Signature: _____ Date:_____

Height: _____ Weight:_____ Blood Pressure:_____ /_____

Dr. Casey LaPierre ~ Location: 63A Elm Street Topsham ME 04086 ~Phone: 207-502-4119

Email: chirotransformation@gmail.com