

~ WELCOME ~

Dr. Lisa's Family Chiropractic & Natural Health Care

Dr. Lisa Marsh
Chiropractic Physician



First _____
Last _____
Nickname _____
Address _____
City _____
State _____
Zip _____
SS# _____
Gender _____
Marital Status _____
Date of Birth _____
Start Date _____

Contacts:
Home Phone _____
Work/Alt Phone _____
Cell Phone _____
Email _____
Work/Alt Email _____
Emergency Contact _____
Fax _____
Occupation _____
Whom may we thank for referring you?

Responsible Party

Name of person responsible for this account _____
Relationship to patient _____
Address _____
City _____ State _____
Zip _____ Phone Number _____

Do you have Insurance? _____ Would you like us to verify coverage _____
If so, please present your card to the front desk

If you do not have **OUT of NETWORK** benefits on your policy, please note that patients are responsible for payment in full at the time of service.

**We require a 24 hour notification on any canceled appointment.
Failure to do will result in a \$45.00 No- Show fee.**

Patient Signature _____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

TREATMENT: What type of treatment are you looking for?

- I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
 I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
 I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition? Y N

If yes, whom? _____ Treatment(s): _____

Have you had any intolerance or reactions to treatments? Y N Describe: _____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____ Has it become worse recently? Y N Same Better Gradually worse

How frequent is the condition? Constant Daily Intermittent Night only How long does it last? All day Few hours Minutes

Is this condition interfering with your: Work Sleep Daily routine Recreation Other: _____

How long has it been since you really felt good? Days Weeks Months Years >10 years

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other: _____

What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other: _____

Is there anything that you can do to relieve the problem? Y N If yes, describe: _____

If no, what have you tried to do that has not helped? _____

What do you believe is wrong with you? _____

Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? _____

Have you been in an auto accident? Past year Past 5 years Over 5 years Never

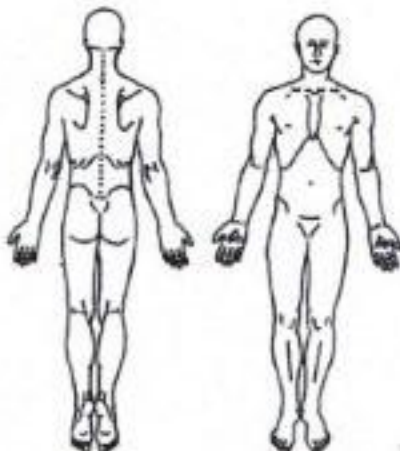
Describe: _____

Please check all of the symptoms that apply. (P=Past / C= Current)

- | | | |
|--|---|---|
| P / C | P / C | P / C |
| <input type="checkbox"/> Headache | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tingling in Feet |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Sore Muscles |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Weak Muscles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Fullness of Bladder | <input type="checkbox"/> Shakiness |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Urination Difficulty | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Impatience |
| <input type="checkbox"/> Unpleasant Taste | <input type="checkbox"/> Elbow / Hand Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Tingling in Hands | <input type="checkbox"/> Feel Loss of Control |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Clammy Hands | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lump in Throat | <input type="checkbox"/> Low Back Pain | |
| <input type="checkbox"/> Swallowing Pain | <input type="checkbox"/> Hip Pain | |
| <input type="checkbox"/> Unsteady Voice | <input type="checkbox"/> Knee Pain | |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Poor Circulation | |
| <input type="checkbox"/> Persistent Coughing | <input type="checkbox"/> Swollen Joints | |
| <input type="checkbox"/> Chest Pressure | <input type="checkbox"/> Joint Stiffness | |
| <input type="checkbox"/> Slow Heart Rate | <input type="checkbox"/> Swollen Ankles | |
| <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Ankle / Foot Pain | |

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

- Stabbing/Cutting - ||
Burning - XXX
Numbness - ———
Tingling - :::
Cramping - ^^^
Dull - ###



ALLERGIES: Please check and list all allergies.

- Food: _____
- Medications: _____
- Seasonal / Other: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
<input type="checkbox"/> Antacids		
<input type="checkbox"/> Antibiotics		
<input type="checkbox"/> Antidepressants		
<input type="checkbox"/> Anti-Diabetics		
<input type="checkbox"/> Anti-Inflammatory		
<input type="checkbox"/> Blood Pressure Lowering Meds.		
<input type="checkbox"/> Cholesterol Lowering Meds.		
<input type="checkbox"/> Hormone Replacements (HRT)		
<input type="checkbox"/> Oral Contraceptives		
<input type="checkbox"/> Other		

SCARS / SURGICAL PROCEDURES: List all scars and surgical procedures you have had. _____**SUPPLEMENTS:** Do you take Vitamins/Supplements or Herbs? Y N If yes, who recommended them? _____**HABITS:**

	Heavy	Moderate	Light	None		5-7x/wk	3-5x/wk	1-3x/wk	Note	Type	Time
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs	
Soda / Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		5+	4	3	2		
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meals / day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		64+ oz	32-64 oz	16-32 oz	<8 oz		
					Water / day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

WORK ACTIVITY: Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking / Moving Driving**FAMILY HISTORY:** Identify any conditions that you, or any of your family members have now or have had in the past:
(G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self)

- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Miscarriage(s) | <input type="checkbox"/> Tumor(s) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcer(s) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pleurisy | Other: _____ |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Detached retina | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Stroke | |

Patient's Printed Name _____

Patient's Signature _____

Date _____

Updated 08/06/04

OFFICE POLICY

CONSULTATION \$45.00

The purpose of this consult is for the doctor and prospective patient to meet face-to-face or over the phone and briefly discuss the patient's concerns. Dr. Lisa will then determine how treatment in our office could benefit your case. Also, she will outline the diagnostics needed to evaluate the case and review the specific fees.

FEES

The complete history and examination may vary depending upon the circumstances and tests that need to be performed. Additional diagnostic and/or lab test may be needed and you will be advised of those fees before they are incurred. Specific treatments, natural medicines and/or further diagnostic tests may be recommended which will be reviewed and explained along with their specific fees.

INSURANCE

We will accept your PPO insurance plan and will file the paperwork. You are responsible for the portion of the services that are not covered by the insurance company.

Personal Injury Protection (i.e. Auto Accidents): We will accept an authorization of direct payment on Florida Personal Injury Protection Insurance once the appropriate form from our office is signed. You will be responsible for the balance if your insurance covers a percentage of charges that are accumulated.

Worker's Compensation: We do not accept Florida Worker's Compensation Insurance on pre-authorized claims.

Medicare: This office does accept assignment on Medicare, therefore, the insurance forms will be sent in and any monies paid will go directly to the doctor. The patient will be responsible for any balance not covered by Medicare (e.g. exceeding number of visits allowed by Medicare).

METHOD OF PAYMENT

Payment is due when services are rendered. Cash, personal checks, MasterCard, Visa and Discover are accepted. There is a \$25.00 charge for checks returned due to non-sufficient funds.

MISSED APPOINTMENTS

Unless the appointment is cancelled within 24 hours of your scheduled time, you will be charged the FULL amount of your office visit. This includes Doctor's visits, Hyperbaric Oxygen sessions, Foot Baths, Massage Therapy, etc.

I understand and agree to the above policies.

Patient Signature _____ Date _____

Notice: Cancellation Fee

Regarding Appointment Cancellations:

There have been an increasing number of patient appointments cancelled at the last minute; this makes it very hard to get others in who need an appointment when the schedule is full.

All cancellations need to be made at least 24 hours before scheduled appointment or a \$45.00 fee will be charged to your account.

Thank you for your understanding and cooperation

Patient
Signature _____

Dr. Lisa