Dr. Lori Sprague

7110 S Mingo Rd, Ste 107 Tulsa, OK 74133
(918) 252-9915 • Fax (918) 252-9102
(866) 900-9915 Toll-Free
www.sonarchiropractic.com

New Patient Information

Date: _____/_____/_____

Title you prefer: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Pastor

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient Name: _____
Legal First Middle Last Nickname

Address: _____
Street City State Zip

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ E-Mail: _____

Which phone number do you prefer we use to contact you? ☐ Home ☐ Cell ☐ Work

Sex: ☐ Male ☐ Female Social Security #: _____-_____-_____ Birth date: _____/_____/_____ Age: _____

Employer: _____ Occupation: _____

Who may we thank for referring you? _____

Spouse or Legal Guardian (if under 18) Information

Spouse/Guardian Name: _____
Legal First Middle Last Nickname

Address: _____
Street City State Zip

Social Security #: _____-_____-_____ Birth Date: _____/_____/_____ Age: _____

Employer: _____ Occupation: _____

Cell Phone (_____) _____ Work Phone (_____) _____

Closest Living Relative (Someone not living with you, in case of emergency.)

Name: _____ Relationship: _____

Home Phone (_____) _____ Cell Phone (_____) _____

Other Information

Have you ever been diagnosed with cancer? _____ If yes, when? _____

Complaint Area #1: _____

How often do you experience your symptom? ☐Constantly (76-100% of the time) ☐Occasionally (26-50% of the time) ☐Frequently (51-75% of the time) ☐Intermittently (1-25% of the time)

How would you describe the type of pain? ☐ Sharp ☐Numb ☐Dull ☐ Tingly ☐Diffuse ☐Shooting ☐Achy ☐Shooting with motion ☐ Burning ☐Stabbing with motion ☐Sharp with motion ☐Stiff ☐ Electric like with motion ☐Other: _____

How is your symptom changing with time? ☐Worse ☐Staying the Same ☐ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ☐ No ☐ Yes ☐ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Complaint Area #2: _____

How often do you experience your symptom? ☐Constantly (76-100% of the time) ☐Occasionally (26-50% of the time) ☐Frequently (51-75% of the time) ☐Intermittently (1-25% of the time)

How would you describe the type of pain? ☐ Sharp ☐Numb ☐Dull ☐ Tingly ☐Diffuse ☐Shooting ☐Achy ☐Shooting with motion ☐Burning ☐Stabbing with motion ☐Sharp with motion ☐Stiff ☐ Electric like with motion ☐Other: _____

How is your symptom changing with time? ☐Worse ☐ Staying the Same ☐ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ☐ No ☐ Yes ☐ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Patient Name: _____ **DOB:** ____/____/____

Complaint Area #3: _____

How often do you experience your symptom? ☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time) ☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the type of pain? ☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Shooting ☐ Achy ☐ Shooting with motion ☐ Burning ☐ Stabbing with motion ☐ Sharp with motion ☐ Stiff ☐ Electric like with motion ☐ Other: _____

How is your symptom changing with time? ☐ Worse ☐ Staying the Same ☐ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ☐ No ☐ Yes ☐ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Complaint Area #4: _____

How often do you experience your symptom? ☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time) ☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the type of pain? ☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Shooting ☐ Achy ☐ Shooting with motion ☐ Burning ☐ Stabbing with motion ☐ Sharp with motion ☐ Stiff ☐ Electric like with motion ☐ Other: _____

How is your symptom changing with time? ☐ Worse ☐ Staying the Same ☐ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ☐ No ☐ Yes ☐ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Patient Name: _____ **DOB:** ____/____/____

How would you rate your overall Health? ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

What type of exercise do you do? ☐Strenuous ☐Moderate ☐Light ☐None

Place a check if any of your immediate family members have the following:
☐RA ☐Diabetes ☐Lupus ☐Heart Problems ☐Cancer ☐ALS

List all prescription and over-the counter medications you are currently taking: _____
_____

List all vitamins and other supplements you are currently taking: _____
_____

Have you seen a Chiropractor before? ☐ No ☐ Yes If yes, how long ago? _____

What were the results? ☐ Great ☐ Good ☐ Fair ☐ Mixed ☐ Poor ☐ Other:_____

List all hospitalization, surgical procedures and significant past traumas: _____
_____

Is there anything else the doctor needs to know about you or your health? _____

Are there any diseases that you have been diagnosed with by your medical doctor (please list)?_____
_____

I verify these statements are true to the best of my knowledge:

Signature_____ **Date:** _____
Patient or Parent/Guardian

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Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

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.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, 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 another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation. However, we may use other procedures to help your body hold the adjustments.

I, _____, have read and fully understand the above statements.

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)

Consent to evaluate and adjust a minor child

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.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____/_____/_____

_____ _____/_____/_____
(Signature) (Date)

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature: _____ Print Name: _____Date_____/_____/_____