Welcome to Prather Chiropractic Services, LLC.

Your contact information and complaint history are very important to us.
Dr. Prather would like you to take a moment and fill in the information below. Thank you!

Patient Information: Please Print. ***Date:_____***

Name:_____SS#: _____ - _____ - _____ Sex: ❒ Male ❒ Female

Mailing Address:_____

City_____State_____Zip_____

Phone: (H)_____(W)_____(Cell)_____

Date of Birth: _____/_____/_____ Age: _____ Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Email: _____@_____

Occupation:_____ Employer: _____

Primary Physician: _____

Emergency Contact:_____ Relationship:_____

Phone: (H)_____(W)_____(Cell)_____

Policy Holder Name:_____ Policy Holder Date of Birth: _____/_____/_____

We are grateful that our practice grows by referral. Whom may we thank for referring you to us?

_____

Have you ever seen a Chiropractic Physician before? Yes [ ]
No [ ] Then don't worry! We will explain everything as we go.

Health History:

Current Medical Conditions:

1	4
2	5
3	6

Medications / Supplements + Dosage:

1	3
2	4
5	6
7	8
9	10

Current Allergies:

1	3
2	4

Surgical History:

1	3
2	4

Traumas:

1	3
2	4

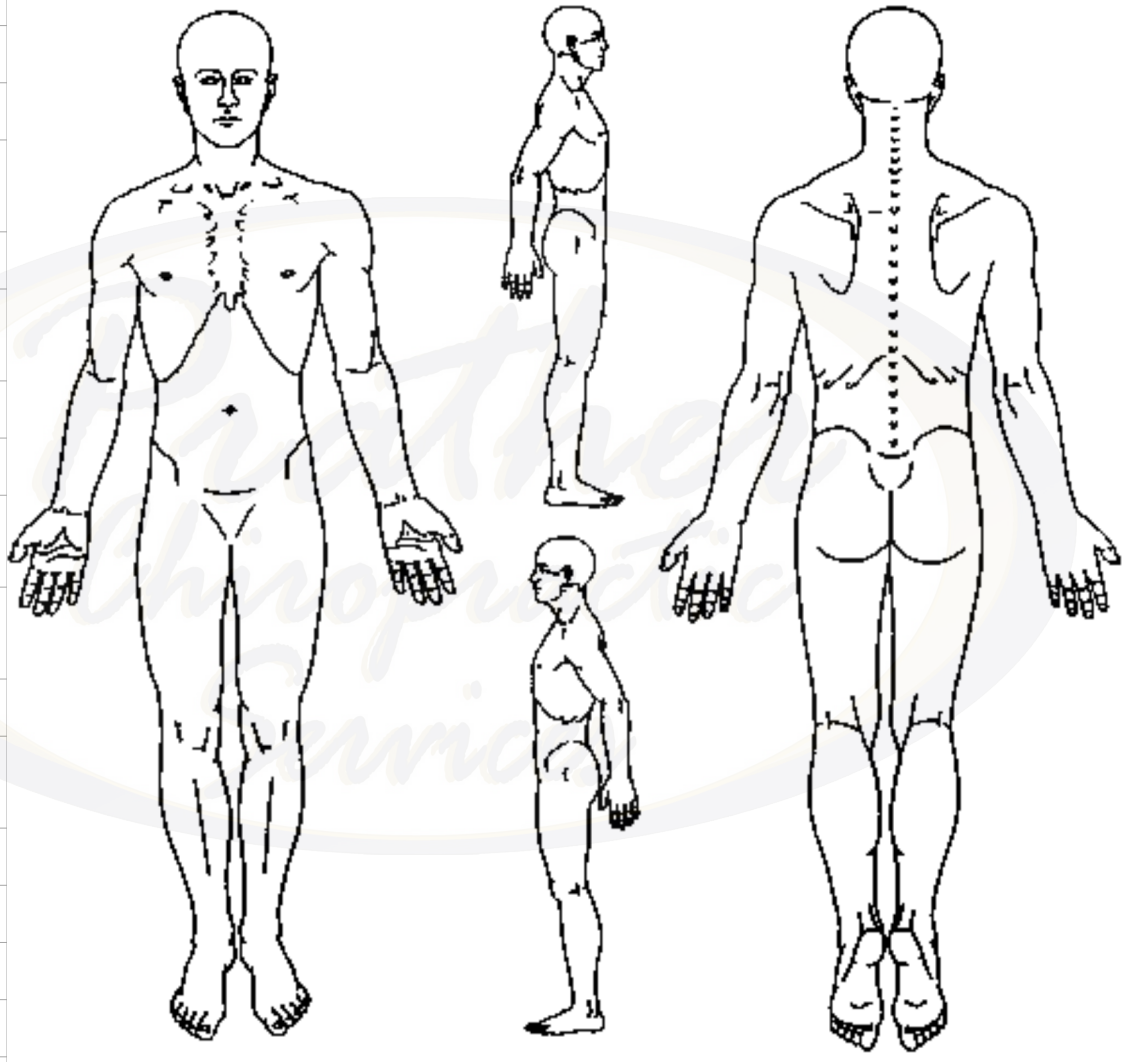
COMPLAINT(S) HISTORY

✏ Are you having pain? ❒ No ❒ Yes If Yes, circle all areas:

Head	Face	Neck	Chest	Shoulders	Elbows	Wrists	Hands
Upper Back	Lower Back	Abdomen	Pelvis	Hips	Knees	Ankles	Feet

On the diagram below, use key to indicate the type and area of pain or symptoms you're experiencing right now.

AS	Ache Superficially
AD	Ache Deeply
B	Burning
C	Cramping
DS	Dizzy - Spinning
D	Dull
ES	Electric Shock
L	Lightheaded
N	Nausea
NT	Numbness & Tingling
PN	Pins & Needles
R	Radiating
RE	Ringing in Ears
SH	Sharp
SO	Shooting
ST	Stabbing
SF	Stiff
SW	Swelling
TH	Throbbing
TI	Tight



✏ When did pain begin?

❒ Childhood

❒ Adulthood

Date Pain Began:_____ / _____ / _____

Date of Accident / Injury:_____ / _____ / _____

My Initials: _____ Date: _____

Dr.'s Initials: _____

✏ Please circle the single best number for each row:

How did Pain Begin?	1. Fall	2. Motor Vehicle Collision	3. Bending	4. Lifting	5. Slept Wrong
	6. Sports Injury	7. Twisting	8. Repetitive Trauma	9. Unknown	10. Other _____
Pain Intensity	1. No Pain	2. Mild Pain	3. Moderate Pain	4. Severe Pain	5. Worst Possible Pain
Sleeping	1. Perfect Sleep	2. Mildly Disturbed Sleep	3. Moderately Disturbed Sleep	4. Greatly Disturbed Sleep	5. Totally Disturbed Sleep
Personal Care	1. No Pain, No Restrictions	2. Mild Pain, Mild Restrictions	3. Moderate Pain, Need to Go Slowly	4. Moderate Pain, Need Some Assistance	5. Severe Pain, Need 100% Assistance
Travel	1. No Pain on Long Trips	2. Mild Pain on Long Trips	3. Moderate Pain on Long Trips	4. Moderate Pain on Short Trips	5. Severe Pain on Short Trips
Work	1. Can Do Usual Work & Limitless Extra Work	2. Can Do Usual Work & No Extra Work	3. Can do 50% of Usual Work	4. Can do 25% of Usual Work	5. Cannot Work
Recreation	1. Can do all Activities	2. Can do most Activities	3. Can do some Activities	4. Can do few Activities	5. Cannot do any Activities
Frequency of Pain	1. No Pain	2. Occasional Pain 25% of the day	3. Intermittent Pain 50% of the day	4. Frequent Pain 75% of the day	5. Constant Pain 100% of the day
Lifting	1. No Pain with Heavy Weight	2. Increased Pain with Heavy Weight	3. Increased Pain with Moderate Weight	4. Increased Pain with Light Weight	5. Increased Pain with Any Weight
Walking	1. No Pain, Any Distance	2. Increased Pain After 1 Mile	3. Increased Pain After 1/2 Mile	4. Increased Pain After 1/4 Mile	5. Increased Pain With All Walking
Standing	1. No Pain After Several Hours	2. Increased Pain After Several Hours	3. Increased Pain After 1 Hour	4. Increased Pain After 1/2 Hour	5. Increased Pain With Any Standing

My Initials: _____ Date: _____

Dr.'s Initials: _____

Daily Habits:

Do you smoke? ❒ Never smoked ❒ Current every day smoker ❒ Current some day smoker
❒ Former smoker If yes, how many packs day? _____ If yes, years? _____

Caffeinated Beverages: ❒ None ❒ _____# Daily ❒ _____# Weekly ❒ _____ # Monthly

Alcoholic Drinks: ❒ None ❒ _____# Daily ❒ _____# Weekly ❒ _____ # Monthly

Exercise Frequency: ❒ None ❒ _____# Daily ❒ _____# Weekly ❒ _____ # Monthly

Review of Systems:

Musculoskeletal: Please check all that apply ❒ Arm/hand pain ❒ Feet/leg pain
❒ Hip pain ❒ Knee pain ❒ Lower Back Pain ❒ Mid Back Pain ❒ Muscle spasm
❒ Neck Pain ❒ Pelvic Pain ❒ Joint Redness ❒ Shoulder Pain ❒ Stiffness ❒ Upper Back Pain

Cardiovascular / Respiratory: Please check all that apply ❒ None ❒ Chest pain
❒ Chest tightness ❒ Cold hands/feet ❒ Coughing up blood ❒ Coughing up phlegm
❒ Difficulty breathing ❒ Fainting ❒ Palpitations ❒ Persistent cough ❒ Shortness of breath
❒ Sudden awakening with shortness of breath ❒ Swelling of extremities ❒ Wheezing

Head / Neck: Please check all that apply ❒ None
❒ Dizziness ❒ Facial pain ❒ Grinding teeth ❒ Headache ❒ Head injury
❒ Jaw clicks ❒ Lumps ❒ Migraines ❒ Spasming Neck ❒ Stiff Neck
❒ Swollen glands ❒ Trouble swallowing ❒ Other _____

Eyes: Please check all that apply ❒ None
❒ Blurred Vision ❒ Burning ❒ Cataracts ❒ Double vision ❒ Dryness ❒ Flashing lights
❒ Glasses/contacts ❒ Glaucoma ❒ Itching ❒ Pain ❒ Redness ❒ Specks

Ears: Please check all that apply ❒ None
❒ Buzzing in ears ❒ Decreased hearing ❒ Drainage ❒ Earache ❒ Ear infections
❒ Poor balance ❒ Poor hearing ❒ Ringing in ears (tinnitus)

Nose: Please check all that apply ❒ None ❒ Allergies ❒ Blocked Sinuses
❒ Discharge ❒ Excessive mucus ❒ Hay Fever ❒ Itching ❒ Nose bleeds
❒ Sinus pressure / pain ❒ Other _____

My Initials: _____ Date: _____

Review of Systems Continued:

Throat/Mouth: *Please check all that apply* ❒ *None* ❒ *Bleeding*
❒ *Blue lips* ❒ *Braces* ❒ *Dentures* ❒ *Difficulty swallowing* ❒ *Dry mouth*
❒ *Hoarseness* ❒ *Mouth pain* ❒ *Non healing sores* ❒ *Redness* ❒ *Sore throat*
❒ *Sores on lips or tongue* ❒ *Swollen tonsils* ❒ *Thrush* ❒ *Tooth problems*
❒ *Other* _____

Urinary: *Please check all that apply* ❒ *None*
❒ *Blood in urine (hematuria)* ❒ *Burning or pain* ❒ *Difficulty urinating* ❒ *Frequent UTI's*
❒ *Frequent urination* ❒ *Incontinence (unable to hold urine)* ❒ *Kidney infections*
❒ *Kidney Stones* ❒ *Water Retention* ❒ *Other* _____

Gastrointestinal: *Please check all that apply* ❒ *None*
❒ *Change in appetite* ❒ *Change in bowel habits* ❒ *Constipation* ❒ *Diarrhea*
❒ *Heartburn* ❒ *Nausea* ❒ *Rectal bleeding* ❒ *Swallowing difficulties*
❒ *Yellow eyes or skin (jaundice)* ❒ *Other* _____

Endocrine: *Please check all that apply* ❒ *None*
❒ *Change in appetite* ❒ *Cold intolerance* ❒ *Dry Skin* ❒ *Excessive thirst*
❒ *Excessive urination* ❒ *Heat intolerance* ❒ *Oily Skin* ❒ *Skin tags*
❒ *Sweating* ❒ *Weight Gain* ❒ *Weight Loss* ❒ *Other* _____

Vascular/Hematologic: *Please check all that apply* ❒ *None*
❒ *Calf pain with walking (claudication)* ❒ *Cold hands and feet* ❒ *Ease of bleeding*
❒ *Ease of bruising* ❒ *Leg Cramps* ❒ *Skin discoloration* ❒ *Varicose veins*

Neurologic: *Please check all that apply* ❒ *None*
❒ *Vertigo* ❒ *Fainting* ❒ *Memory confusion* ❒ *Memory loss* ❒ *Muscle loss (atrophy)*
❒ *Muscle weakness* ❒ *Neuralgia* ❒ *Numbness* ❒ *Poor concentration*
❒ *Seizures* ❒ *Tingling* ❒ *Tremors* ❒ *Other* _____

Psychiatric: *Please check all that apply* ❒ *None* ❒ *Anxiety* ❒ *Depression*
❒ *Easily angered / Irritable* ❒ *Frequent crying* ❒ *Nervousness* ❒ *Stress*
❒ *Suicidal thoughts* ❒ *Other* _____

My Initials: _____ ***Date:*** _____

Review of Systems Continued:

Female: *Please confirm if you are pregnant at this time so you are clear for X-Ray examination:*

Are you pregnant? ❒ *Yes* ❒ *No* *Date of last period* _____

Number of days between periods _____ *Age Started* _____ *Age Stopped* _____

Number of pregnancies _____ *Number of deliveries* _____ *Number of miscarriages* _____

Number of abortions _____ *Number so Cesareans* _____

Please check all that apply ❒ *None* ❒ *Clotting* ❒ *Dark Color* ❒ *Discharge* ❒ *Food cravings* ❒ *Heavy bleeding* ❒ *Hot flashes* ❒ *Infections* ❒ *Irregular periods* ❒ *Itching or rash* ❒ *Light bleeding* ❒ *Little/no sex drive* ❒ *Menstrual pain/ cramps* ❒ *Missed periods* ❒ *Mood swings* ❒ *Painful breasts* ❒ *Pain with sex* ❒ *STD's* ❒ *Vaginal discharge* ❒ *Vaginal Dryness* ❒ *Vaginal sores*

❒ *Other*_____

Male: *Please check all that apply* ❒ *None* ❒ *Erectile Dysfunction* ❒ *Hernia* ❒ *Impotence* ❒ *Low sex drive* ❒ *Masses or pain* ❒ *Pain with sex* ❒ *Penile discharge* ❒ *Prostate problems* ❒ *Sores* ❒ *STD's*

❒ *Other*_____

Illnesses: *Please check all that apply* ❒ *None*

❒ *AIDS/HIV*	❒ *Chronic Fatigue*	❒ *Heart Disease*	❒ *Miscarriage*	❒ *Seizures*
❒ *Anemia*	❒ *Depression*	❒ *Hepatitis*	❒ *Multiple sclerosis*	❒ *Stroke*
❒ *Arthritis*	❒ *Diabetes*	❒ *Hernia*	❒ *Osteoporosis*	❒ *Suicide Attempt*
❒ *Asthma*	❒ *Emphysema*	❒ *Herniated Disc*	❒ *Pacemaker*	❒ *Thyroid Problems*
❒ *Bleeding disorder*	❒ *Epilepsy*	❒ *Hypertension*	❒ *Parkinson's*	❒ *Turberculosis*
❒ *Breast lump*	❒ *Fibromyalgia*	❒ *High Cholesterol*	❒ *Pinched nerve*	❒ *Tumors/Growths*
❒ *Bronchitis*	❒ *Fractures*	❒ *Immune deficiency*	❒ *Prostate problems*	❒ *Ulcers*
❒ *Cancer*	❒ *Gallstones*	❒ *Kidney Disease*	❒ *Prosthesis*	❒ *Vaginal Infections*
❒ *Chemical Dependency*	❒ *Glaucoma*	❒ *Liver Disease*	❒ *Psychiatric Issues*	❒ *Venereal Disease*
❒ *Chicken Pox*	❒ *Gout*	❒ *Migraines*	❒ *Rheumatism*	❒ *Whooping Cough*

❒ *Other* _____

Are you having any trouble whatsoever controlling your bowel and/or bladder function? ❒ *Yes* ❒ *No*

Are you having any facial sagging or drooping? ❒ *Yes* ❒ *No*

My Initials: _____ ***Date:*** _____

SIGNATURE PAGE:

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practices for Prather Chiropractic Services, LLC regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by the clinic and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting Megan Chessher at (337) 984-3113 and or visiting 1803 W. Pinhook Rd, Lafayette, La. 70508

My signature herein below constitutes full acknowledgement that I have been furnished a copy of the Notice of Privacy Practices for Prather Chiropractic Services, LLC.

Signature: _____ Date: _____

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

Signature: _____ Date: _____

BILLING AND PAYMENT:

For your treatment at Prather Chiropractic Services, LLC, payment may be made by any of the following methods: Please indicate your method of payment below:

___ ***Self Pays:*** *If you have no available insurance coverage you will be billed for services provided.*

___ ***Health Insurance:*** *Prather Chiropractic Services, LLC will bill your health insurance provider if at the time of service we are a contracted provider with that insurance company. However, you must remit all payments due as a result of any deductible, co-insurance, and co-payments per the insurance plan. These payments, as well as payments for services not covered under the plan, are due at the time each service is rendered.*

___ ***Third Party Faulty:*** *In the event that a third party is at fault for your injury and you wish for Prather Chiropractic Services, LLC to bill that third party or your automobile medical payments carrier instead of your health insurer, then we will attempt to collect from the third party at the full cost of our services. However, in the event that third party recovery is unsuccessful, then you will be responsible for the full amount of the outstanding medical bill.*

Signature: _____ Date: _____

ASSIGNMENT AND RELEASE:

I certify that all the above questions have been answered accurately, and I understand that giving the incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed to this office. I authorize the use of this signature on all insurance claims, including electronic submissions. I've provided a current driver's license and insurance card.

Signature: _____ Date: _____

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

Our practice specializes in treating problems of the spine and associated disorders of the nervous system. A large proportion of our patients come via referral from their medical practitioner. As such, it is standard practice to correspond with your medical practitioner where appropriate.

Please (Circle) and complete the following:

☐ *I GIVE consent for my clinical information to be communicated to my general practitioner where appropriate.*

☐ *I DO NOT GIVE consent for my clinical information to be communicated to my general practitioner where appropriate.*

_____

(Signature)

_____

(Print Name)

_____

(Date)

Notice of Privacy Practices (3/03) (Please Keep For Your Records)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.

If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to

PRIVACY OFFICER, 1803 W. Pinhook Rd., Lafayette, LA 70508