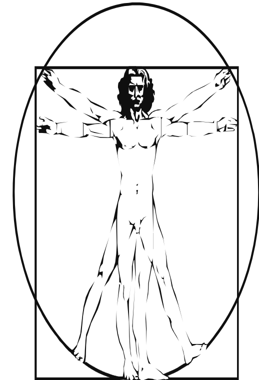
Lake Tahoe Wellness Center

Office policy

Thank you for your confidence in seeking modern Chiropractic as a method to restore your health *Naturally.* Shortly, you will be interviewed by the doctor. After reviewing your completed, confidential health questionnaire, should the doctor feel that your condition be best treated by another health practitioner, you will be advised and referred accordingly. However, should your condition fall within the scope of Chiropractic, a thorough consultation will be undertaken to document your case history. A comprehensive Chiropractic examination will then be conducted to determine the cause of your problem(s).
The examination consists of:



- ✓ *Postural analysis*
- ✓ *Physical examination*
- ✓ *Orthopedic and Neurological examination*
- ✓ *Specific Chiropractic examination*
- ✓ *Radiology (if required)*

You will most likely receive an adjustment with this first visit. This will be discussed with you. After this initial session, examination findings will be interpreted. During your second visit, the doctor will explain her findings and will make recommendations as to the Chiropractic Adjustment Program required in your particular case.

Please Note: In order to achieve the maximum benefit from your Chiropractic Adjustments, it is necessary to follow the program outlined by Dr. Kuehne.

FEE SCHEDULE

Procedure	Fee
Consultation	Complimentary
Examination	$90.00
X-rays	$80.00 to $190.00
Adjustments	$45.00
Re-examinations	$20.00
Packages	vary
Supplements etc.	ask Tiff

Dr Lily M. Kuehne, DC

Your Case History

Name: ____ Date: __________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Please circle your preference of phone number we use to contact you.

Mailing Address: _________________________________ City/State/Zip: _________________

Date of Birth: ___________ Soc. Sec. No. : ____________ Email address: ________________

Would you like to receive news regarding our office via email? ____Yes ____No

Employed by________________________________Occupation:________________________

Marital Status: Single Married Divorced Widowed

Spouse's Name: __________________ Children's names and ages: _____________________

Who can we thank for referring you to our office? _____________________________________

What can we help you with?

<u>Check all that apply:</u>

Optimum performance and wellness lifestyle

General return to good health

Specific complaint (Please describe)____

____

____

If you are experiencing pain, is it: Sharp Dull Burning Achy Stiff
Comes & goes Constant Radiating
Mild Moderate Severe

Others consulted for the same or similar health challenge: _____________________________

Have you ever visited a chiropractor? ____Yes ____ No.

If yes, who and for what reason? ____

If injured, please briefly describe: The date of injury: _________________

____

____

Medications that you currently take: ____

Vitamins/supplements that you currently take: ____

<u>How does your health challenge affect your:</u>

Work: ____

Relationships: ____

Play Time: ____

Please rate the following statements from 1 to 10. 1 is the lowest, 10 is the highest:

The healthiest you have ever been in your life: _______

Your current level of health: _______

Your desire for a lifetime of health: _______

Dis-ease Process

Answer these questions as they relate to your history

	MAYBE	YES	NO	Describe if applicable
Did/do you play any contact sports?	( )	( )	( )	______________________
Any car accidents as a child?	( )	( )	( )	______________________
Any physical trauma as a child?	( )	( )	( )	______________________
Any emotional trauma as a child?	( )	( )	( )	______________________
Were you exposed to second hand smoke?	( )	( )	( )	______________________
Did/do you have frequent colds?	( )	( )	( )	______________________
Did you use prescription drugs as a child?	( )	( )	( )	______________________
Any allergies as a child?	( )	( )	( )	______________________
Any allergies as an adult?	( )	( )	( )	______________________
Do/did you smoke?	( )	( )	( )	______________________
Do/did you drink alcohol?	( )	( )	( )	______________________
Have you had any surgery?	( )	( )	( )	______________________
Have you had any bad slips or falls?	( )	( )	( )	______________________
Have you had any car accidents?	( )	( )	( )	______________________
Have you fallen off a bike?	( )	( )	( )	______________________
Have you ever fractured a bone?	( )	( )	( )	______________________
Do/did you lift small children?	( )	( )	( )	______________________
Do you sit excessively?	( )	( )	( )	______________________
Have you had any other accidents?	( )	( )	( )	______________________
Do you lift heavy weights?	( )	( )	( )	______________________
Is your bed adequate & up to date?	( )	( )	( )	______________________
Do you sleep well?	( )	( )	( )	______________________
Do you watch your posture?	( )	( )	( )	______________________

Have you experienced any of the following recently? Please circle all that apply:

Depression   Anxiety   Economic stress   Death
Job stress   Family problems   Other stresses

Please check any symptom that you have experienced in the past five years

___Headaches	___Neck pain	___Numbness in arms/hands	___Arm pain
___Visual changes	___Limited motion of neck	___General stiffness	___Pain in ears
___Ear infection	___Loss of hearing	___Sinus infection	___Frequent colds/flu
___Dizziness	___Asthma	___Fainting	___Excessive fatigue
___Shoulder pain	___Pain between shoulders	___Loss of motion in back	___Heartburn
___Arthritis	___Muscle spasms in back	___Pain after eating	___Constipation
___Diarrhea	___Pain relieved by eating	___Irritable Bowel	___Weight loss
___Chest pain	___Sciatic pain	___Heart disease	___Stroke
___Anemia	___High/low blood pressure	___ADD/ADHD	___Breast pain/lumps
___Low back pain	___Numbness in feet/legs	___Knee pain	___Hip pain
___Foot pain	___Leg pain on exertion	___Leg pain at rest	___Frequent urination
___Difficult urination	___Bladder infection	___Premenstrual syndrome	___Menstrual cramps
___Osteoporosis	___Cancer		

Family History. Please list all concerns:

Children: ______________________ Spouse: ____________________________________

Mother or Father: ____

Brothers/Sisters: _______________________________ Grandparents: _______________

Others: ____

Health Process

	YES	NO	MAYBE		YES	NO	MAYBE
Do you get good rest?	( )	( )	( )	Do you drink quality water?	( )	( )	( )
Do you eat quality food?	( )	( )	( )	Do you get along with friends & family?	( )	( )	( )
Do you exercise properly?	( )	( )	( )	Do you get regular spinal adjustments?	( )	( )	( )

Lake Tahoe Wellness Center

Terms of Acceptance and Informed Consent

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for us both to be working towards the same objective. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.

If during the course of the 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 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. 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 subluxations.

A patient in coming to the Doctor of Chiropractic, requests and consents to the performance of chiropractic adjustments and other chiropractic procedures and analysis, including if necessary, diagnostic x-rays. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not give a Chiropractic adjustment or health care, if she/he is aware that such care may be contra-indicated. It is the patient's responsibility to make it known or to learn through health care procedures whatever he/she is suffering from. A Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

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 adjustments to 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.

I ___________________________ have read and fully understand the above statements.
(Print name)
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 of patient/parent or guardian) (Witness to signature) (Date)

Lake Tahoe Wellness Center
Notice of Privacy Practices

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

Summary:
By law, we are required to provide you with our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information, and;
6. The right to a paper copy of this Notice.

We want to assure your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice: January 1, 2009

Contact Person: ***Tiffany***

Phone Number: ***530-546-8201***

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that this practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be changed in any way.

____________________________ _______________________________ _________________
Patient/parent/guardian **print name** Patient/parent/guardian **sign name** **Date**

( ) Patient refused to sign
( ) Patient was unable to sign because of: ____