

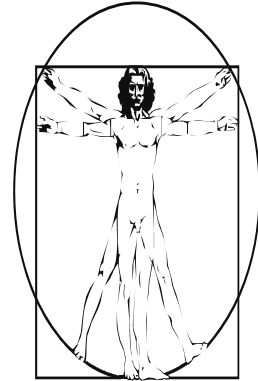
# Lake Tahoe Wellness Center

## 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

| <u>Procedure</u>       | <u>Fee</u>           |
|------------------------|----------------------|
| <u>Consultation</u>    | <u>Complimentary</u> |
| <u>Examination</u>     | <u>\$90.00</u>       |
| <u>Read Xrays</u>      | <u>\$40.00</u>       |
| <u>Adjustments</u>     | <u>\$45.00</u>       |
| <u>Re-examinations</u> | <u>\$20.00</u>       |
| <u>Other Supplies</u>  | <u>Ask our Tiff</u>  |

**Dr. Lily M. Kuehne D.C.**

# 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?

### Check all that apply:

- 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: \_\_\_\_\_

### How does your health challenge affect your:

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**

|  | <b>MAYBE</b> | <b>YES</b> | <b>NO</b> | <b>Describe if applicable</b> |
|--|--------------|------------|-----------|-------------------------------|
| 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**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Neck pain               | <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Arm pain           |
| <input type="checkbox"/> Visual changes      | <input type="checkbox"/> Limited motion of neck  | <input type="checkbox"/> General stiffness      | <input type="checkbox"/> Pain in ears       |
| <input type="checkbox"/> Ear infection       | <input type="checkbox"/> Loss of hearing         | <input type="checkbox"/> Sinus infection        | <input type="checkbox"/> Frequent colds/flu |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Excessive fatigue  |
| <input type="checkbox"/> Shoulder pain       | <input type="checkbox"/> Pain between shoulders  | <input type="checkbox"/> Loss of motion in back | <input type="checkbox"/> Heartburn          |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Muscle spasms in back   | <input type="checkbox"/> Pain after eating      | <input type="checkbox"/> Constipation       |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Pain relieved by eating | <input type="checkbox"/> Irritable Bowel        | <input type="checkbox"/> Weight loss        |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Sciatic pain            | <input type="checkbox"/> Heart disease          | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> ADD/ADHD               | <input type="checkbox"/> Breast pain/lumps  |
| <input type="checkbox"/> Low back pain       | <input type="checkbox"/> Numbness in feet/legs   | <input type="checkbox"/> Knee pain              | <input type="checkbox"/> Hip pain           |
| <input type="checkbox"/> Foot pain           | <input type="checkbox"/> Leg pain on exertion    | <input type="checkbox"/> Leg pain at rest       | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Difficult urination | <input type="checkbox"/> Bladder infection       | <input type="checkbox"/> Premenstrual syndrome  | <input type="checkbox"/> Menstrual cramps   |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Cancer                  |   |   |

**Family History.** Please list all concerns:

Children: \_\_\_\_\_ Spouse: \_\_\_\_\_  
 Mother or Father: \_\_\_\_\_  
 Brothers/Sisters: \_\_\_\_\_ Grandparents: \_\_\_\_\_  
 Others: \_\_\_\_\_

**Health Process**

|                           | <b>YES</b> | <b>NO</b> | <b>MAYBE</b> |   | <b>YES</b> | <b>NO</b> | <b>MAYBE</b> |
|---------------------------|------------|-----------|--------------|---|------------|-----------|--------------|
| 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?  | ( )        | ( )       | ( )          |

# 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, 9**

**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: \_\_\_\_\_

**Lake Tahoe Wellness Center**  
695 Wolf St. Box 2979, Kings Beach, CA. 96143  
(530) 546-8201

**Parent/Guardian Consent Form**  
**For persons under 18 years of age:**

I, \_\_\_\_\_ consent to Chiropractic examination, analysis,  
Chiropractic spinal adjustments or X-rays (if necessary) for \_\_\_\_\_  
at the office of Dr. Lily M. Kuehne , D.C.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date