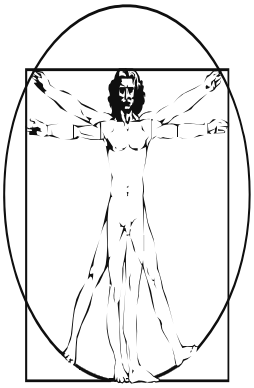
Lake Tahoe Wellness Center

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?

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

	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: _____