Langas Chiropractic

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FEE SCHEDULE (subject to change)

Initial Orientation Visit $105.00
New or first-time visits may include:
- Physical evaluation - functional physiology and structural/posture
- Introduction to basic concepts of chiropractic care
- Report of our findings
- Computerized Bio-Meridian Stress Assesment

Computerized Bio-Meridian Stress Assesment. $25.00

Heart Rate Variability $25.00

Initial Visit - Children 17 & Under. $95.00

Individual Adjustment Visits $50.00
- Basic chiropractic visit without extended or advanced work

Individual Adjustment Visit for Children 17 Years and Younger $40.00

Extended Visit Charge* $60.00
- Includes basic adjustment
- Extended nutritional or advanced testing
- Extended cranial technique work
- Additional percussion work
- NeuroEmotional work

* Extended visit charge may apply to a person who has not been in the office within the past 6 months and additional work is necessary to determine course of treatment on that particular visit, per discretion of the doctor.

OFFICE POLICIES

1. Our practice is a general chiropractic health care practice. We do not accept personal injury cases that have the potential of being litigated. Therefore, we...
   A. Do not accept Worker's Compensation cases.
   B. Do not accept accident cases (vehicle or otherwise) that were caused by another person, business, or vehicle, or have the potential of being litigated.
   C. Do not accept Medicaid.
2. X-rays are not made to determine when or where to adjust, as this is determined by neuro-muscular stress testing.

   X-rays are needed to determine if any disease process, fracture, malformation, or spinal degeneration is present that would make spinal adjusting contraindicated.
3. Your acceptance as a patient is based on my findings relative to your symptoms and their relationship to your neuro-musculo-skeletal manifestations. The acceptance of your case does not promise a cure; however, it does indicate by my evaluation you have definite neuro-musculo-skeletal indicators that could have a relationship to your symptoms.
4. It is the policy of our office that you pay completely for services when they are rendered.
5. We endeavor to serve our patients to the best of our ability and professional training and we expect you, by becoming a patient to follow the doctor's recommended treatment program. This is necessary to gain optimum benefit in your case.

If you have any questions concerning any of the policies above, please contact the front desk BEFORE continuing with your forms.

By signing this policy sheet, you are stating you understand and will abide by the policies.

Signed:_____ Date: _____

Witnessed:_____

PATIENT INFORMATION

Name_____

Address _____

City_____ ST____ Zip _____

Phone (H)_____ (Cell) _____

Email _____

Date of Birth ___/___/___ Social Security # _____

Occupation_____ Employer_____

Marital Status S M D W Spouse's Name _____

Spouse's Occupation_____

Number of Children____ Ages_____

Have you ever received chiropractic care? ☐ Yes ☐ No

Referred by _____

Case History _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

over

THIS SIDE MUST BE COMPLETED AS WELL.

LOSS OF WHOLE BODY HEALTH (Age 5 - Present)

As you increased the layers of damage you probably began to experience symptoms and random bouts of sickness.

Yes	No	(Age 5 -present)	Patient Comment if answer is Yes	Chiropractor's Comments
☐	☐	Were you taught proper body movement and care?		
☐	☐	Did/do you smoke?		
☐	☐	Did/do you drink any alcohol?		
☐	☐	Diet (Do you eat healthy foods?)		
☐	☐	Have you been in accidents?		
☐	☐	Have you had surgery and organs removed/replaced?		
☐	☐	Drugs? (Prescriptive or non-prescriptive)		
☐	☐	Teeth problems?		
☐	☐	Eye problems?		
☐	☐	Hearing problems?		
☐	☐	Exercise regularly?		
☐	☐	Sleeping habits (nightmares?)		
☐	☐	Did/do you have occupational stress?		
☐	☐	Physical stress?		
☐	☐	Mental stress?		
☐	☐	Hobbies/Sports injuries?		
☐	☐	Other traumas or problems		
		Sleeping posture ☐ Side ☐ Stomach ☐ Back		

SYMPTOMS AND ILL HEALTH (Present State of Ill Health)

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Major present complaint (be brief) _____ Started on _____

Pains are ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work?_____ Sleep?_____ Routine?_____ Other?_____

Is condition getting progressively worse? _____

Other doctors seen for this condition _____

Any home remedies? _____

Other symptoms:

- ☐ Headaches
- ☐ Neck Pain
- ☐ Sleeping Problems
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Face Flushed
- ☐ Neck Stiff
- ☐ Pins & Needles in Legs
- ☐ Pins & Needles in Arms
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Lights Bother Eyes
- ☐ Loss of Memory
- ☐ Ears Ring
- ☐ Fever
- ☐ Fainting
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Hands Cold
- ☐ Stomach Upset
- ☐ Constipation
- ☐ Cold Sweats
- ☐ Loss of Balance
- ☐ Buzzing in Ears

Have you been under drug and medical care?_____

What medications are you taking? _____

How long?_____ Have you had surgery?_____ What?_____ When?_____

What side effects have you experienced from the drugs and surgery? _____

Is there a family history of: _____