Patient Information

Date _____ SS# _____

Name _____
(Last)

_____
(First) (M.I.)

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Number of Children _____ Ages _____

Occupation _____

Employer/School _____

Address _____

_____

Spouse's Name _____

Spouse's Birthdate _____

Spouse's Employer _____

Primary Care Physician _____

Previous Chiropractor _____

Financial Policy Agreement

I understand that with the exception of work-related injuries, I am ultimately responsible for the payment of the services rendered to me at

_____
(Signature)

Insurance Provider _____

Are you taking medications?

Prescriptions: _____

_____

_____

_____

Non-Prescription: _____

Vitamins/Minerals: _____

_____

Daily Habits

Do you...

☐ Smoke _____ packs a day
☐ Drink Alcohol _____ drinks a day
☐ Drink Caffeine/Coffee _____ drinks a day

How is your...

☐ Stress Level: High Moderate Low None
☐ Work Activity: Sitting Standing Light Labor Heavy Labor
☐ Exercise Level: Heavy Daily Moderate None

Phone Numbers

Home _____ Work _____

Cell or other _____

Best time and place to reach you: _____

In case of emergency:

Name _____

Phone _____

Health History

Please check all that apply:

☐ Diabetic
☐ High Blood Pressure
☐ Breast Implants
☐ Pacemaker
☐ Currently Pregnant

When did you last feel good? _____

Patient Condition

Major complaint _____

Other complaints _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No

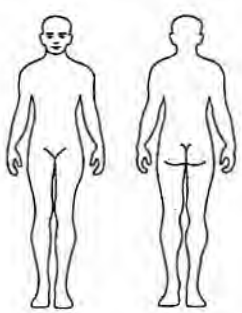
Is it constant or does it come and go? _____

Rate the severity of your problem on a scale from 1 (least) to 10 (severe pain) _____

Type of symptoms: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Stiffness ☐ Other

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Mark on the picture where you continue to have symptoms



P=Pain N=Numbness S=Spasm T=Tingling

Falls/Accidents/Injuries/Surgeries you had:

	Descriptions	Dates
Falls		
Broken Bones		
Dislocations		
Surgeries		

Dates of previous car accidents: _____

Please check your current symptoms:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Cold Hands / Feet
☐ Neck Pain	☐ Chest Pain	☐ Shortness in Breath	☐ Buzzing in Ears	☐ Leg Pain
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Depression	☐ Fainting	☐ Constipation / Diarrhea	☐ Sleeping Problems	☐ Head Seems to Heavy
☐ Low Back Pain	☐ Cold Sweats	☐ Pins & Needles in Arms	☐ Light Bothers Eyes	☐ Shoulder Pain
☐ Nervousness	☐ Ears Ringing	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Numbness in Fingers
☐ Tension	☐ Mid Back Pain	☐ Fever	☐ Other _____	

Date of last: Physical Exam _____ Spinal Exam _____ Spinal X-Ray _____ MRI / CT Scan _____

Personal Injury Questionnaire

Accident Information

Date _____ Time of Day _____
Type of accident ☐ Auto ☐ Work ☐ Other
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Police ☐ Other
Name of supervisor _____
Have you retained an attorney? _____

How did you feel...

During the accident: _____

Immediately after the accident: _____

_____

Later that day: _____

The next day: _____

1. In your own words, please describe the accident: _____

_____

_____

_____

2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Aware of the accident
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____ Type of vehicle _____
4. Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
5. Approximate speed of your car? _____ mph Other car? _____ mph Damage to your car? $_____
6. Were you: ☐ Unconscious Did you receive: ☐ Cuts ☐ Bruises ☐ Other _____
7. What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other
8. Name and address of other doctor(s) or facilities (ER, AMPM, etc.) you have seen concerning this condition:

_____

9. Have you lost time from work as a result of this accident? ☐ Yes ☐ No How Long? _____
10. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No
11 Is the pain worse when: ☐ Working ☐ Lifting ☐ Stooping ☐ Standing ☐ Sitting ☐ Bending ☐ Coughing ☐ Sleeping ☐ Walking

Other Information: _____

_____

_____ _____

(Signature) **(Date)**

HEALTH QUESTIONNAIRE

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

Patient:_____ **Date:**_____ **No.:**_____

MUSCULO SKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?
☐ YES ☐ NO

GASTRO-INTESTIONAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Drug Abuse
- ☐ _____

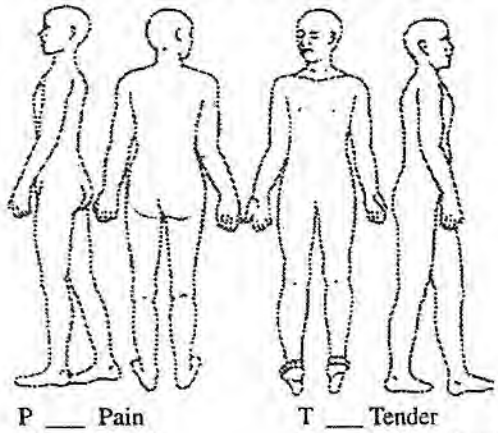
CARDIO-VASCULAR RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw Pain

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

••••••••••••••••••••••DO NOT WRITE BELOW THIS LINE••••••••••••••••••••••

_____

_____

_____

_____

Patient Accepted? ☐ Yes ☐ No **Doctor's Signature**_____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW ALL INFORMAATION CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnosis or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health care Operations: We may use or disclose, as needed; your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required uses and disclosures: Under the law, we must make disclosures to you, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other Permitted and Required uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, accept to the extent that you physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient Signature: _____