PATIENT CONFIDENTIALITY PERSONAL DATA

No._____ **Date**_____
Patient:_____ **Date of Birth:**_____
Home Address:_____ **City:**_____ **State:**____ **Zip:**_____
Social Security No.:_____ **Home Phone:**_____ **Mobile:**_____
Work Phone:_____ **Email:**_____
Employer:_____ **Address:**_____
Name of Spouse:_____ **SS No.:**_____ **No. of Children:**____
Spouse's Employer:_____ **Address:**_____
How did you learn of this clinic?_____
Nearest relative not living with you?_____ **Phone:**_____
Who is responsible for payment? ☐ **Self** ☐ **Spouse** ☐ **Other**_____

PATIENT'S INSURANCE
Name of Company:_____
Address:_____
ID & Group No.:_____
Phone No.:_____

SPOUSE'S INSURANCE
Name of Company:_____
Address:_____
ID & Group No.:_____
Phone No.:_____

Purpose of this appointment and list your complaints:_____
_____
Date of illness: _____ **Time:**____ ☐ **AM** ☐ **PM Location:**_____
How did accident occur? ☐ **Auto** ☐ **On the job** ☐ **Other,**_____
Please describe the circumstances and what makes the condition(s) better or worse:_____
_____
_____
_____
Other Doctor seen for this condition:_____
Have you been treated by a Doctor for any health condition in the last year? ☐ **Yes** ☐ **No**
If yes, please describe:_____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature Physician:_____ **Signature Patient:**_____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATON

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in any case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature:_____
Parent's or Guardian's Signature:_____

Patient Health Information Consent Form

We want you to know how important your **Patient Health Information** (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your **Patient Health Information** we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractor office to use their **Patient Health Information** (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractor office to submit requested PHI to the **Health Insurance Company** (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatment, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy. Also a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient Signature Date

HEALTH QUESTIONNAIRE

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

Date:_____

Patient:_____ **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

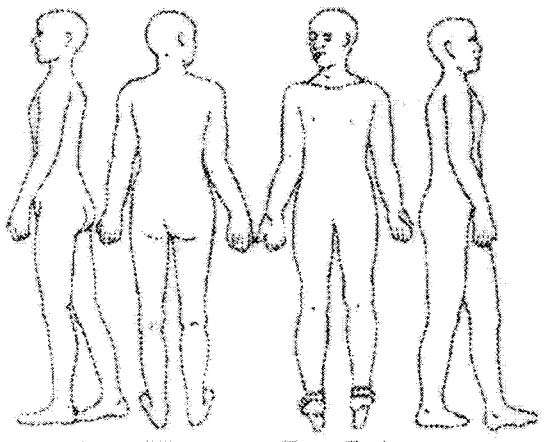
FEMALE

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

ARE YOU PREGNANT?

☐ YES ☐ NO

SYMPTOM LOCALIZATION



P ____ Pain T ____ Tender
N ____ Numb H ____ Hypoesthesia
S ____ Spasm

Pain Index

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

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

Patient's Signature _____

●●●●●●●●●●●●●●●●●●●●●●DO NOT WRITE BELOW THIS LINE●●●●●●●●●●●●●●●●●●●●●●

_____

_____

_____

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

Patient Primary Complaint Form

Name: _____ ____ Date: _____

What is the number one thing that bothers you the most TODAY?

_____

_____

When did your pain begin? _____

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Is your condition: Getting better Getting worse

Is your condition: On & off or Constant

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & sore

Radiating: Left/Right Base of Skull Shoulder Arm Hand Hip Leg Knee Foot Ribs Other: _____

What makes it better? Ice Heat Rest Movement Stretching Other: _____

What makes it worse? Sitting Standing Walking Lying down Sleep Overuse Other: _____

Have you ever seen anyone else for this condition?

_____

Where you involved in an accident? (Auto, Fall, Work, etc.?)

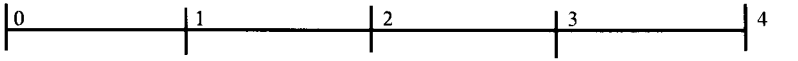
_____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

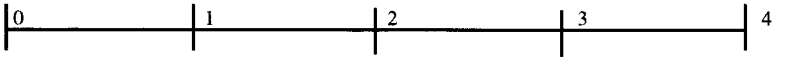
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



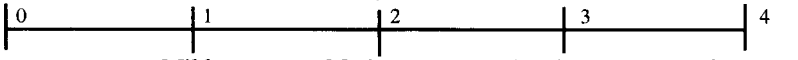
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



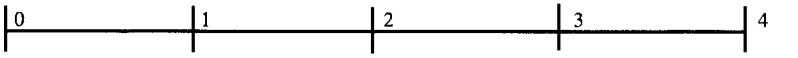
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



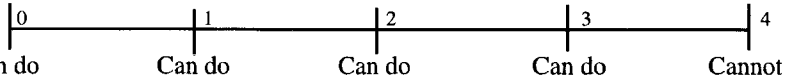
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



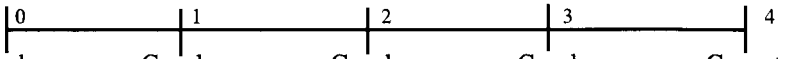
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



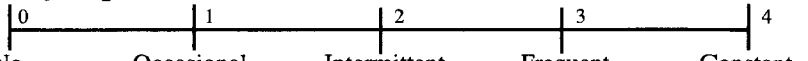
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



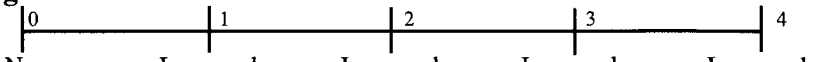
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



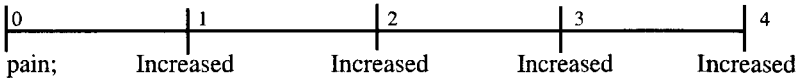
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



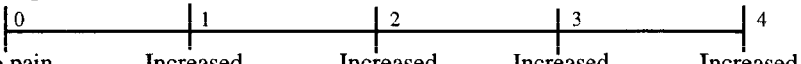
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date