Patient Health History Form

Name:_____ **Date of Birth:**_____ **Gender:** ❑ M ❑ F
Address:_____ **City/State/Zip:**_____
Social Security #:_____ **Marital Status:** ❑Married ❑Single ❑Divorced ❑Widowed
Best Phone #:_____ **Spouse Name:**_____
E-mail:_____ **Emergency Contact:**_____
Age:_____ **Emergency Contact Phone:**_____
Employer:_____ **Work Phone:**_____
Occupation:_____ **Years at Current Employer:**_____
Children?(please list ages):_____
Who referred you to our office?_____

Smoking Status(Circle one): Every day smoker/Occasional smoker/Former smoker/Never smoked

Race(Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Hispanic or Latino/Native Hawaiian or Pacific Islander / Other / I decline to Answer

Are you currently taking any medications?

Medication Name	Dosage, Frequency, Start Date, & Refills

Do you have any medication allergies? (if yes, please list with reaction and onset date):

_____

Past Surgeries (Please list type, date (approx.), and results):

_____

Past Hospitalizations (Please list dates, reasons and which hospital):

_____

Past Serious Illnesses (Please list dates):

_____

Past Immunizations/Tests (Please list dates):

_____

Have you ever been in an accident?: ❑Yes ❑No **If yes, what kind and when?:**_____

_____

Past diseases/medical conditions: _____

_____

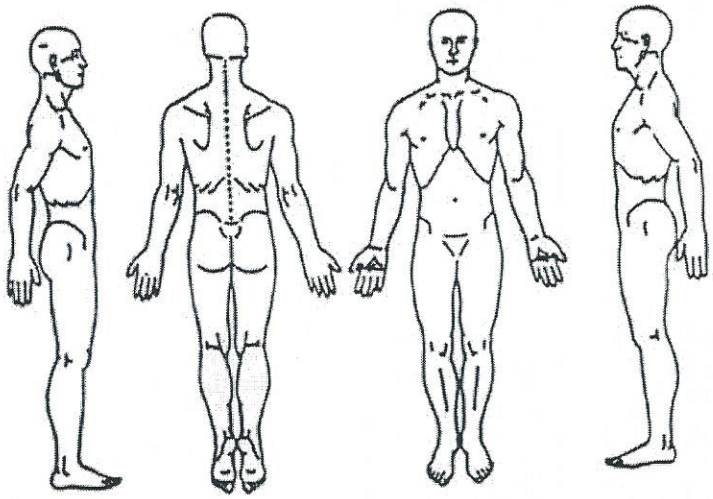
Past family diseases/medical conditions (List relation to family member please): _____

_____

Current Complaints

Primary symptom:_____
When did this condition begin?: _____
How did this condition begin?:_____
Have you had this problem in the past?: ❑Yes ❑No **If yes, how long ago:**_____
How severe is this problem? (Scale of 1-10, with 10 being the worst):_____
Nature of the symtoms (Please check all that apply):
❑*Ache* ❑*Dull* ❑*Burning* ❑*Sharp* ❑*Stabbing* ❑*Shooting* ❑*Stiff* ❑*Tight* ❑*Numb* ❑*Tingling* ❑*Radiating*
How often do you feel the symptoms? ❑*Constant(100%)* ❑*Frequent(75%)* ❑*Occasional (50%)* ❑*Intermittent(25%)*
Does the pain travel to any other areas?: ❑No ❑Yes-**Where to?:**_____
What aggravates your condition?:_____
Have you done anything to relieve the pain?:_____
Nature of Injury: ❑Automobile ❑Work ❑Other
Other doctors seen for this complaint: _____
Previous doctors opinion/diagnosis:_____
Have you ever been under chiropractic care?: ❑Yes ❑No
Have you had x-rays taken? ❑Yes ❑No **If yes, where and what year?:**_____

Please mark on this chart with an "X" where you are having the symptoms at:



Are you experiencing any numbness or tingling? If yes, please circle the area on the chart above.

Primary Care Physician:_____ **Date of last physical:**_____
Is there a chance that you are pregnant? ❑Yes ❑No
Do you drink caffeine: ❑Yes ❑No **If yes, how often?:** _____
Do you drink alcohol: ❑Yes ❑No **If yes, how often?:** _____
Do you exercise: ❑Yes ❑No **If yes, how often and what forms?:** _____
Any additional comments:_____
_____

Patient signature: _____
Date: _____

CHECK ANY OF THE FOLLOWING THAT APPLIES TO YOU:

- ❒ Polio
- ❒ Diabetes
- ❒ Cancer
- ❒ Heart
- ❒ Chronic Fatigue
- ❒ Arthritis
- ❒ Epilepsy
- ❒ AIDS or ARC
- ❒ Frequent Illnesses
- ❒ Allergies

INTAKE or USE:

- ❒ Alcohol
- ❒ Tobacco
- ❒ Pain Relievers
- ❒ Prescribed Drugs
- ❒ Recreational Drugs
- ❒ Other:_____

CHECK ANY PROBLEMS AREAS THAT YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCLES-SKELETON

- ❒ Low Back
- ❒ Middle Back
- ❒ Neck
- ❒ Arm
- ❒ Joints
- ❒ Walking
- ❒ Jaw – TMJ
- ❒ General Stiffness

CIRCULATION-BREATHING

- ❒ Chest
- ❒ Breathing
- ❒ Blood Pressure
- ❒ Heart Rate
- ❒ Heart
- ❒ Lungs
- ❒ Stroke

EYE-EAR-NOSE-THROAT

- ❒ Visual
- ❒ Dental
- ❒ Throat
  - ❒ Ear
- ❒ Hearing
- ❒ Nose
- ❒ Sinus
- ❒ Forehead Or Face

NERVE SYSTEM

- ❒ Headaches
- ❒ Nervousness
- ❒ Numbness/Tingling
- ❒ Muscular Weakness
- ❒ Dizziness
- ❒ Forgetfulness
- ❒ Depression
- ❒ Fainting
- ❒ Convulsions/Seizures
- ❒ Cold Hands/Feet
- ❒ Stress

DIGESTION-ELIMINATION

- ❒ Poor Appetite
- ❒ Excessive Thirst
- ❒ Nausea
- ❒ Diarrhea
- ❒ Constipation
- ❒ Hemorrhoids
- ❒ Weight Loss/Gain
- ❒ Gas/Bloating
- ❒ Heartburn
- ❒ Change in Stools

URINARY-GENITALS

- ❒ Pain Upon Urination
- ❒ Infrequent Urination
- ❒ Frequent Urination
- ❒ Weak Urine Stream
- ❒ Bladder Control
- ❒ Genitals

FEMALE ONLY

- ❒ Menstrual
- ❒ Low Back w/Periods
- ❒ Breast

Sign:_____ Date:_____

Patient Health Information Consent Form

We want you to know how 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 chiropractic 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 chiropractic 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 not obligated to agree to those restrictions.
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 consent at any time during care. This would not effect 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. For your security and right to privacy, all staff has been trained in the area of patient record privacy and 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. 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.

_____ _____

Name of Patient Date

DOCTOR-PATIENT RELATIONSHIP AND CONSENT FORM

CHIROPRACTIC

It is important to acknowledge the difference between health care specialties of Chiropractic, Osteopathy and Medicine. It is also important for the patient to understand what to expect from chiropractic care. It is the chiropractic premise that proper spinal alignment allows normal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. In this way, chiropractic seeks to restore health through natural means without the use of drugs or surgery. The success of chiropractic procedures often depends on environment, underlying causes and the physical and spinal conditions of each individual patient. It is also important that the patient understand what to expect from chiropractic care. Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The Doctor of Chiropractic provides a specialized, unique, non-duplicating health service. The Doctor of Chiropractic is licensed in a special area of practice and is available to work with other type of providers in your health care regime.

ANALYSIS

Your doctor will conduct a clinical analysis for the express purpose of determining whether there is evidence that your situation may be the result of a vertebral subluxation and that you might respond satisfactorily to chiropractic care. If such is found, chiropractic care will be recommended in an attempt to restore spinal integrity.

RESULTS

The purpose of chiropractic care, is to promote natural health through the reduction of the vertebral subluxation. Since there are so many variables, it is difficult to predict the time schedule or the efficacy of the chiropractic adjustments on any given patient. Sometimes the response in phenomenal, however, in most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same type of care and actual response is not predictable. Many medical failures have found significant benefit through chiropractic care. In turn, conditions which do not respond to chiropractic care may come under the control or be helped through medical treatment. Chiropractic and medicine may never be so exact as to provide definite answers to all problems, however, both have made great strides in patient care.

DIAGNOSIS

Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine, and its effects on the nerve system, they are not internal medical specialists. Every patient should be mindful of his/her own symptoms and should secure other opinions should he/she have any concerns as to the nature of his/her condition . Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

By signing below, the patient gives the doctor permission and authority to care for him/her in accordance with recognized and acceptable chiropractic analytical and corrective procedures. The chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give an adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through other health care procedures whether he/she is suffering from: pathological conditions (latent of otherwise), illnesses, injures, or deformities which would otherwise not come to the attention of the doctor.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.

I have read and understand the foregoing. I hereby give my consent for the doctor to render chiropractic care to me.

_____ _____

Patient's Signature **Date**