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CONFIDENTIAL PATIENT INFORMATION (Adult)

Dear Patient, **Please read and complete this questionnaire <u>in detail.</u>** Your answers will help us determine if chiropractic can assist you. If we do not seriously believe your condition will respond satisfactorily, we will not accept your case.

Name: First ____________________ MI ______ Last ____________________________ Age: ______

Address: ______________________ City: ______________ State: ______ Zip: __________

Home Phone: (_____) __________ Work Phone: (____) ________ Date of Birth: __________

Occupation: ______________ Employer: ______________ E-mail: __________________

SSN: ______________ Marital Status: M W D S Spouse's Name: ____________________

Children's Name & Ages: ____

____

Most patients are referred to our office by a caring family member or friend. Who may we thank for referring you to our office? ____

Research shows that your spine should be checked regularly. When was your last spinal examination, including x-rays? ____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Briefly describe the area of complaint, including the effect it has had on your life. __________

____

Since the problem started is it: About the same Getting better Getting worse

What makes it worse? ____

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

When did your problems first appear? ____

Have you experienced this in the past? Yes / No

Please complete other side →

Have you seen another doctor for this condition? Y / N If so, who?

Chiropractor(s): ______________________ or Medical Doctor(s): ______________________

Has anyone in your family experienced similar problems? Y / N If so, who? ______________

Do you suffer from any condition other than that for which you are consulting us? Yes / No

Please explain: ____

BODY SIGNALS

Please circle **ALL** symptoms (body signals) you have ever had, even if they do not seem related to your current problem.

Headaches	Pins and needles in legs	Fainting	Neck pain
Loss of smell	Pins and needles in arms	Back pain	Loss of balance
Dizziness	Buzzing in the ears	Fatigue	Nervousness
Depression	Numbness in fingers	Loss of taste	Upset stomach
Irritability	Numbness in toes	Tension	Sleeping problems
Diarrhea	Ringing in the ears	Cold hands	Cold feet
Constipation	Lights bother eyes	Fever	Hot flashes
Heartburn	Menstrual irregularity	Menstrual pain	Ulcers
Cold sweats	Problem Urinating	Mood swings	Neck stiffness

Stress can cause or accelerate spinal damage. Rate your stress level over the past 90 days.

Low/1 2 3 4 5 6 7 8 9 10 /High

Poor posture leads to poor health and often indicates a spinal condition.

How would you rate your posture? Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent

Prescription medications may cause various side effects, hide the severity of health conditions, and/or hinder the body's ability to heal. What medications are you currently taking? ______

____

Insurance Information

If you are insured and wish for us to assist you in submitting your claims, please provide us with your insurance card and Social Security Number so that we may make a copy and verify your coverage in this office.

Patient's Signature: ______________________________ Date: ____________

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 IT 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.

1. Uses and Disclosures of Protected Health Information

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 your 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 diagnose 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.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's 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, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.