

CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
LAST NAME

Address _____
FIRST NAME MIDDLE INITIAL

City _____ State ZIP _____

Home Phone _____

Cell Phone _____

Email _____

Sex M F Age _____ Birthday _____

Married Widowed Single Minor

Separated Divorced Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10
NO SYMPTOMS INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:

What does it feel like? (check where appropriate)

Numbness Sharp

Tingling Shooting

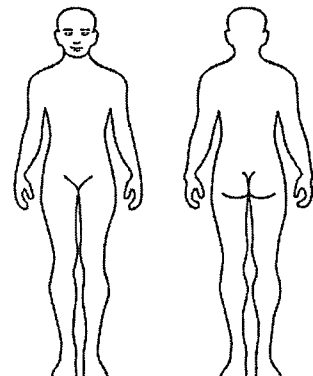
Stiffness Burning

Dull Throbbing

Aching Stabbing

Cramping Swelling

Nagging Other _____



IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

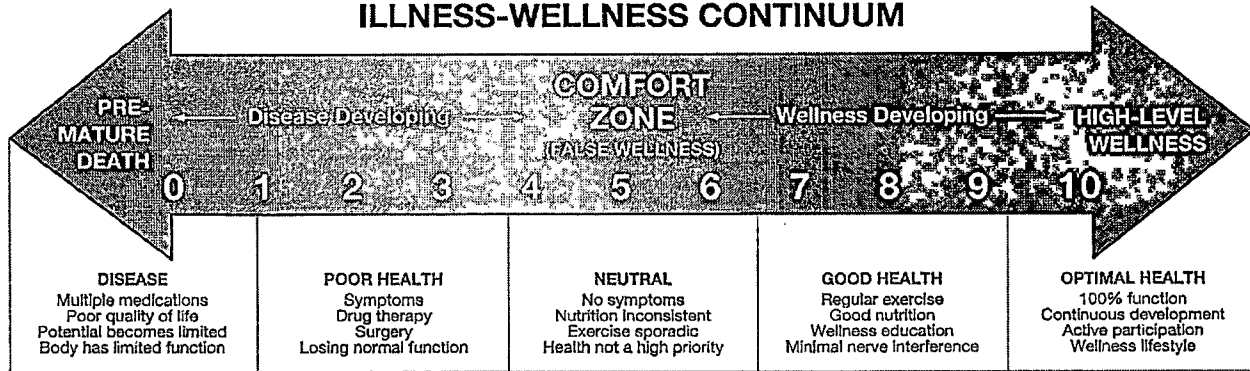
	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10
NOT COMMITTED VERY COMMITTED

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM



On the arrow diagram above:

- A. What number do you think represents your health today? _____
- B. In what direction is your health currently headed? _____

What are your health goals?

- IMMEDIATE _____
- SHORT TERM _____
- LONG TERM _____

CHILDREN & PREGNANCY

- How many children do you have? _____ Are you currently pregnant? No Yes, I am due _____
- Childrens' ages? _____ Number of past pregnancies? _____
- Childrens' health concerns? _____ Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Circulation Issues | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Childhood Illness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shoulder Issues |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hip Issues | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Issues
(Constipation/Diarrhea/GERD/IBS) | <input type="checkbox"/> Immune Issues | <input type="checkbox"/> TMJ Issues |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Elbow/Wrist/Hand Issues | <input type="checkbox"/> Lymphatic Issues | <input type="checkbox"/> Urinary Issues |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Endocrine Issues (Thyroid) | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> Foot/Ankle Issues | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Reproductive Issues | _____ |

ALLERGIES, MEDICATIONS & SUPPLEMENTS

- | | | |
|------------------|--------------------|--------------------|
| ALLERGIES (list) | MEDICATIONS (list) | SUPPLEMENTS (list) |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Sports and Spine Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Jennifer at (972) 248-4994. If she is unavailable, you may make an appointment with our receptionist to see her /him within 72 hours or 3 working days . If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _____-retaining page 1 of 2

_____ **Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....**

I have received a copy of _____ Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name

DOB

HR#

Patient signature

Date

Witness

Date