SCOTT FAMILY HEALTH

Chiropractic | Massage | Acupuncture | Physical Therapy

Patient Health History Form

Today's Date: ____/____/_____

Patient Information:

Patient First Name:	**Middle Initial:**	**Last Name:**

Patient Address:		
Patient City:	**Patient State:**	**Patient Zip:**
Home Phone:	**Mobile Phone:**	**E-mail:**
Date Of Birth:	**Gender:**	**Marital Status:**

Pregnant ❑ Yes ❑ No **How many weeks** _____

Race *(check one)*

	American Indian		Asian		African American
	Hispanic or Latino		Native Hawaiian or Other Pacific Islander		White
	Other:		I choose not to Specify		

Ethnicity *(check one)*

	Hispanic or Latino		Not Hispanic or Latino		I choose not to specify

Preferred Language *(check one)*: _____

Have you traveled out of the U.S. recently ❑ Yes ❑ No **If yes, where** _____

Social History:

			If Yes, Frequency/ Type/ Amount
Have you ever used Tobacco:	Yes	No	
Do you consume alcohol?	Yes	No	
Do you consume Caffeine?	Yes	No	
Do you exercise?	Yes	No	
Have you used recreational drugs:	Yes	No	

Medications:

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

NAME	Start Date	Frequency	Dosage	NAME	Start Date	Frequency	Dosage

Allergies:

List any known allergies you have had to any medications. If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Brain or Head Trauma:

How many episodes of brain trauma have you had in your life? _____

If 1 or more, please be specific and write down date of occurrence: _____

Surgical History:

Please list any surgeries you have had:

1) _____ **3)** _____

2) _____ **4)** _____

Family History:

Family History: Do any Family Members have any of the following? Please Indicate who has the condition:

Asthma _____ Liver Disease_____

Cancer _____ Seizure Disorder_____

Heart Disease _____ Stroke/ TIA_____

High Blood Pressure _____ Tuberculosis_____

High Cholesterol _____ Ulcers_____

Kidney Disease _____ Other_____

Review of Systems (Circle all that Apply)

Allergic- Immunologic None
Hives HIV/AIDS Allergies Frequent Sinus Trouble

Cardiovascular: None
Murmur Chest Pain Palpitations
Dizziness Shortness of Breath Heart Attack
Swollen Ankles Pain in Left Arm
Low Blood Pressure High Blood Pressure Fainting

Ear/ Nose/ Throat: None
Difficulty Hearing Ringing in Ear Vertigo
Sinus Trouble Hearing Loss Ear Pain
Nose Bleeds Dental Problems Difficulty Swallowing

Endocrine: None
Loss of Hair Heat/ Cold Intolerance Hypothyroidism
Hyperthyroidism Diabetes

Eyes: None
Glasses/ Contacts Eye Pain Light Bothers Eyes
Double Vision Cataracts Vision Problems
Blurred Vision Glaucoma

Gastro- Intestinal: None
Heartburn/ Reflux Nausea/ Vomiting Ulcers
Gallbladder Problems Liver Problems Hepatitis
Colon Cancer Abdominal Pain
Pancreatitis Jaundice

Genitourinary: None
Burning/ Frequency Blood in Urine
Kidney Infection Kidney Stones

Hematology/ Lymph: None
Easy Bruising Enlarged Glands Anemia
Bleeding Disorder Lymphoma

Musculoskeletal: None
Joint Pain/ Swelling Stiffness Muscle Pain
Neck Pain Neck Stiffness Back Pain
Osteoarthritis Rheumatoid Arthritis Bone Spurs
Broken Bones Fractures Head Injury
Back Injury Spinal Trauma
Muscle Weakness Scoliosis

Neurological: None
Loss of Strength Numbness Headaches
Tremors Memory Loss Multiple Sclerosis
Parkinsons Disease Fainting Migraines
Loss of Coordination Difficulty Walking Stroke
Alzheimer's Disease Weakness Dizziness
Epilepsy/ Seizures Tingling

Psychiatric: None
Anxiety Depression Mood Swings
Difficulty Sleeping Nervousness Tension

Integumentary (Skin): None
Rash/Sores Itching/Burning Skin Problems
Slow Healing Psoriasis Skin Cancer

General: None
Recent Weight Gain Loss of Sleep Recent Weight Loss
Loss of Appetite Fatigue Polio
Rheumatic Fever Cancer _____

Male None
Burning on Urination Difficulty in starting urine
Dripping Urination Prostate Trouble Prostate Cancer

Female None
Hot Flashes Vaginal Discharge Nipple Discharge
Menstrual Cramps Premenstrual Depression
Lumps In Breast Hysterectomy

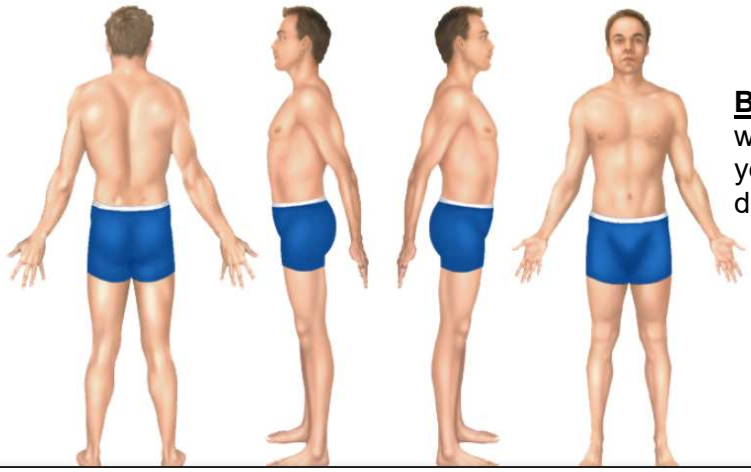
Symptom 1: _____

On a scale from 0-10, with 10 being the worst, please state the number that best describes the symptom most of the time:	
What percentage of the time you are awake do you experience the above symptom at the above intensity:	
When did the symptom begin?	
How did the symptom begin?	
What makes the symptom worse? (Circle all that apply)	Bending Tilting Head Turning Head Tilting at Waist Sitting Getting Up from Sitting Lifting Driving Walking Running Nothing Other:
What makes the symptom better? (Circle all that apply)	Rest Ice Heat Stretching Exercise Massage Medication Nothing Other:
Describe the quality of the symptom?	Sharp Dull Achy Burning Throbbing Stabbing Deep Nagging Other:
Does the symptom radiate to another part of your body? If yes, where?	
Is the symptom worse at certain times of the day or night?	

Symptom 2 _____

On a scale from 0-10, with 10 being the worst, please state the number that best describes the symptom most of the time:	
What percentage of the time you are awake do you experience the above symptom at the above intensity:	
When did the symptom begin?	
How did the symptom begin?	
What makes the symptom worse? (Circle all that apply)	Bending Tilting Head Turning Head Tilting at Waist Sitting Getting Up from Sitting Lifting Driving Walking Running Nothing Other:
What makes the symptom better? (Circle all that apply)	Rest Ice Heat Stretching Exercise Massage Medication Nothing Other:
Describe the quality of the symptom?	Sharp Dull Achy Burning Throbbing Stabbing Deep Nagging Other:
Does the symptom radiate to another part of your body? If yes, where?	
Is the symptom worse at certain times of the day or night?	

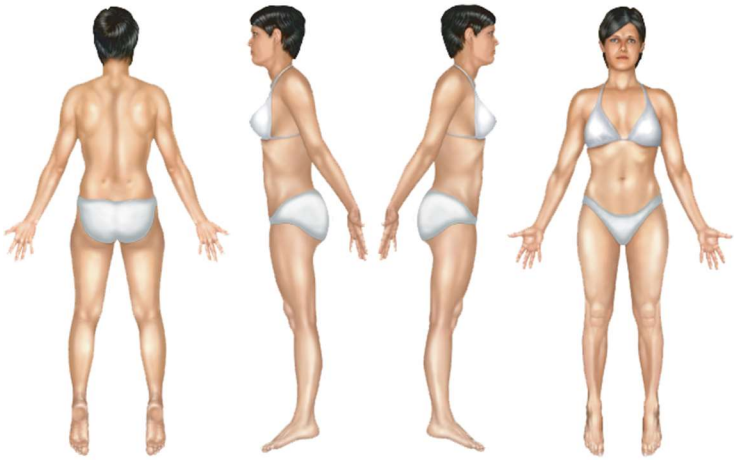
If Male:



Body Diagram: Please indicate on the body where your symptoms are and what type of pain you are experiencing. Use the following to help describe the pain:

N-	Numbness	PN-	Pins and Needles
B-	Burning	D-	Dull Ache
S-	Stabbing	P-	Pain

If Female:



Body Diagram: Please indicate on the body where your symptoms are and what type of pain you are experiencing. Use the following to help describe the pain:

N-	Numbness	PN-	Pins and Needles
B-	Burning	D-	Dull Ache
S-	Stabbing	P-	Pain

Cancellation Policy and Credit Card Authoritzation

We value your time and our provider's time here at Scott Family Health. Therefore, we are strictly enforcing the 24-hour cancellation policy. You may opt-in for e-mails reminders that will be given 48 hours in advance. Any appointments must be cancelled at least 24 hours prior to your scheduled appointment to avoid the cancellation fee. The cancellation fee is $50.00 for all services. We appreciate your understanding.

We provide secured methods of accepting your payment if a cancellation is made with less than 24 hours' notice or if an appointment is missed. We will automatically charge the card on file for $50.00 for any missed appointments or appointments cancelled with less than 24 hours' notice.

I, _____ understand the cancellation policy and authorize Scott Family Health to keep my signature and credit card information on file to charge my account $50.00 if signed cancellation policy is violated.

I am authorizing the use of this card for the Scott Family Health cancellation fee when applicable.

☐ I choose not to write down my card number but have allowed Scott Family Health to enter directly into their system my card ending in (last 4 digits on card) _____

Name of Patient(s): _____ Card #: _____

Card Holder Name: _____ Exp: _____ Security Code: _____

Card Holder Address: _____

Type of Credit Card: VISA _____ MC _____ AMEX _____ DISC _____

Signature: _____

E-mail Opt-In

By providing an e-mail address, you authorize Scott Family Health to send you e-mail communications including marketing and administrative information, including confirmation of your appointments. No personal health information will be sent via e-mail communication. You may opt-out of receiving any such communication at any time by using the opt out feature in the e-mail communication.

By signing below, I am stating that all of the information above is completed to the best of my knowledge and belief true, correct and complete.

_____ _____

Patient or Guardian Signature Date

_____ _____

Print Name Relationship

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HIPAA Privacy Authorization Form/ Notice of Privacy Practices

Authorization of use or disclosure or protected health information

(Required by the Health Insurance Portability and Accountability Act -45 CFR Parts 160 and 164)

Please read the following and sign at the bottom:

I hereby authorize Scott Family Health to view radiology studies that are necessary for my treatment and/ or evaluation through the PAC system provided by Banner Health System, Poudre Valley Hospital, and related affiliates. Requests for other studies and medical information will require a separate request form and my signature. *I understand that these studies may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Hum Immunodeficiency Virus (HIV) and other communicable diseases. Behavioral Health Care/ Psychiatric Care, Treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes the release of any such information.*

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, and/ or other purposes as I may direct.

This authorization shall be in force and in effect until I sign a written request to terminate this agreement. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re- disclosed by the person or organization that received the information.

I release Scott Family Health, its employees, staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

I _____, hereby consent to the use, access and disclosure of my PHI to:

☐ Spouse _____ ☐ Parent/ Guardian_____

☐ Child _____ ☐ Other:_____

By signing below, you agree to the statements presented.

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

_____

WITNESS SIGNATURE DATE