CONFIDENTIAL PATIENT HISTORY

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.
Thank you.

Today's Date____/_____/_____

Last_____First_____MI _____

Street_____City_____State_____Zip Code_____

Phone Number:_____Cell Number: _____

Email:_____

Date of Birth:_____ ❑Male ❑Female SSN:_____-_____- _____

Marital Status: _____ Name of Wife/Husband _____

In Event of Emergency Nearest Relative_____Relationship_____Phone (_____)_____-_____

Heard about our office through_____

Occupation_____Employer_____Work Phone (_____)_____-_____

Address_____

Insurance Information

Primary Insurance Company: _____ID #: _____

Insured's Name_____Relationship_____ Insured's Date of Birth____/____/_____

Phone# (_____)_____-_____Group # (Plan, Local, or Policy #) _____

Reason For Visit

Primary Complaint: _____

Specific Location of Pain: ❑Left ❑Right ❑Center ❑Both

How long have you had this pain:_____What was the approximate starting date of your pain: _____

Have you had this condition in the past? ❑**Yes** ❑**No** If yes, please explain: _____

Pain Level (1 – 10):_____ Intensity of Pain: ❑Mild ❑Moderate ❑Severe ❑Unbearable ❑None

Nature Of Pain: ❑Burning ❑Dull ❑Numb ❑Sharp ❑Shooting ❑Stabbing ❑Tightness ❑Tingling

❑Throbbing ❑Radiating If radiating, what area does the pain radiate towards: _____

Is there pain when you cough or sneeze? ❑**Yes** ❑**No**

What Makes The Pain Better: ❑Acupuncture ❑Chiropractic Therapy ❑Heat ❑Ice ❑Massage Therapy ❑Pain Medicines

❑Physical Therapy ❑Sleep/Rest ❑Stretching ❑Nothing

Expectations: ❑Become Pain Free ❑Explanation of Condition ❑Preventative Information ❑Reduce Symptoms

❑Resume Normal Activity

Frequency of Pain: ❑(76-100% of the day) ❑(51-75% of the day) ❑(26-50% of the day) ❑(0-25% of the day)

Is this condition interfering with your: ❑ **Work** ❑ **Sleep** ❑ **or Daily Routine**

Secondary Complaint: _____

Have you ever been treated by a medical physician or chiropractor for this condition? ❑**Yes** ❑**No**

1. Name_____ When consulted_____ Diagnosis_____

Treatment_____

How long did you see the Doctor?_____ How frequently? _____

Results _____

2. Present Family Doctor or PCP _____

Date of last physical examination_____ By what Doctor_____

Health History

Allergies:

Please check any allergies you have:

☐ Animals	☐ Aspirin/Pain Medicine	☐ Bee Stings	☐ Chocolates/Sweets
☐ Dairy Products	☐ Dust	☐ Eggs	☐ Latex
☐ Molds	☐ X-ray Dye	☐ Ragweed/Pollen	☐ Rubber
☐ Seasonal Allergies	☐ Shellfish	☐ Soaps	☐ Wheat

❑ Other _____

Surgeries:

Please list any surgeries you have had: _____

_____

_____

Medical History:

☐ Ankle Pain	☐ Arm Pain	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Broken Bones	☐ Cancer	☐ Chest Pain
☐ Depression	☐ Diabetes	☐ Dizziness	☐ Elbow Pain
☐ Epilepsy	☐ Eye/Vision Problems	☐ Fainting	☐ Fatigue
☐ Foot Pain	☐ Genetic Spinal Disorder	☐ Hand Pain	☐ Headaches
☐ Hearing Problems	☐ Hepatitis	☐ High Blood Pressure	☐ Hip Pain
☐ Jaw Pain	☐ Joint Stiffness	☐ Knee Pain	☐ Leg Pain
☐ Low Back Pain	☐ Menstrual Problems	☐ Mid Back Pain	☐ Minor Heart Trouble
☐ Multiple Sclerosis	☐ Neck Pain	☐ Neurological Disorder	☐ Pacemaker
☐ Parkinson's Disease	☐ Polio	☐ Prostate Problems	☐ Shoulder Pain
☐ Significant Weight Change	☐ Spinal Cord Injury	☐ Sprain/Strain	☐ Stroke/Heart Attack
☐ Stomach Problems	☐ Tumor	☐ Ulcer(s)	☐ Wrist Pain
☐ Chest Colds	☐ Thyroid Disorder	☐ Menopause Symptoms	☐ Pneumonia

❑ Other: _____

Medication:

What	Dosage	When Do You Take Them (Daily, Monthly, As Needed, etc.)

List any medications you are allergic to: _____

_____

Family Health Information:

Many health problems are the result of hereditary disorders, thus information about your family members will give us a better picture of your total health picture.

NAME	Relation	Past and Present Health Problems

5. Social History (Habits)

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Tobacco	☐ (1-2 Packs a Day)	☐ (½ Pack a Day)	☐ (Less than ½)	❑

7. DATE OF LAST

	Less than 6 months	6-18 months	Over 18 months	Never
Spinal Examination	☐	☐	☐	☐
Physical Examination	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐

Are you a diabetic: ❑Yes ❑No

For Women:

Do you take birth control? ❑Yes ❑No If "Yes" what type? _____

Are you Pregnant? ❑Yes ❑No If "Yes" how far along are you? _____

Date of last menstrual period: _____

Misc. Questionnaire

Preferred Language: _____

Race: ❑Native American ❑Asian ❑African American ❑White ❑Decline Answer

[Doctor's Use Only] Blood Pressure:_____ Temperature:_ Pulse:_____

Height:_____Weight**:** _

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between me and an insurance carrier. Furthermore, I understand that Chiropractic Center for Families will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Chiropractic Center for Families will be credited to my account upon receipt. *However, I clearly understand and agree that all services rendered to me are charged directly and that I am personally responsible for payment. Any account not paid within 90 days will be subject to collections.* I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendation, *my account balance will be immediately due and payable. Medicare patients are responsible for their co-insurance, deductible and any items deemed Medically Unnecessary by Medicare.* If you have insurance that covers your co-insurance and deductible, we will file on your behalf. Any patient 18 years or older will be financially responsible for all charges incurred. For any patient under the age of 18, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred. *A $30 Returned Check Fee will be assessed to your account for every check returned to Chiropractic Center For Families as non-payable.* With the exception of emergency situations, you will be held financially responsible for any scheduled appointment not canceled *at least 24 hours* prior to the appointment. *In the event of default payment, the undersigned agrees to pay all costs of collection of delinquent amounts, including Court costs, and reasonable attorney fees.*

Patient's Signature:_____ Date: _____ /_____ /_____ SSN:_____-_____-_____

Other Responsible Party:_____ Date: _____ / _____ /_____ SSN:_____ -_____- _____

RECORDS RELEASE: I,_____ do hereby authorize Chiropractic Center For Families to release my medical records or copies of such necessary to process this claim.

Patient's Signature:_____ Date:_____/_____/ _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Patient's Signature:_____ Date:_____/_____/ _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop" such noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used. *Possible Risks:* As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could include bone fractures, muscle strain, ligament sprain, joint dislocation, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries or the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritations, burns, or minor complications. *Probability of risks occurring:* The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". *Other treatment options to consider:* Over-the-counter-analgesics; the risks of these medications include irritation to the stomach, liver and kidneys, and other side effects in a significant number of cases. Medical care; typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases. Hospitalization; in conjunction with medical care adds risks of adverse reactions to anesthesia, as well as an extended convalescent period in a significant number of cases. *Risks of remaining untreated:* Delay of treatment allows formation of adhesion's, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult. *Unusual risks:* I have had the following unusual risk of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfactions. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Patient's Signature:_____ Date:_____/_____/ _____

CONSENT TO TREATMENT OF A MINOR CHILD: I hereby authorize Dr. Tori Ritchie and whomever she may designate as assistants to administer chiropractic care as deemed necessary to my (relationship)_____ (Name of Child) _____ dated at (City)_____ (State)_____ this_____ day of_____.

Legal Guardian's Signature:_____ Date:_____/_____/ _____

Notice of Privacy Practices

You should be aware that we utilize an "open adjusting room." We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgment that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgment or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgment that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medial information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement for you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining for Acknowledgment or Authorization.** Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and the event of death. Specifically, we may be required to report certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health0related benefits and services that may be of interests to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in you healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time, In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

1. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to your, or if we are otherwise required by law to make a full disclosure without restriction.
2. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
3. You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
4. All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve- period.
6. If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or the the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.