

PATIENT INFORMATION

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female
 Address: _____ City: _____ State: ____ Zip: _____
 E-mail Address: _____ Home Phone: _____ Mobile Phone: _____
 Work Phone: _____ Social Security #: _____
 Employer: _____ Occupation: _____
 How did you hear about our office? _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____
 Secondary: _____ Third: _____ Fourth: _____

On a scale of **1 to 10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM
 How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

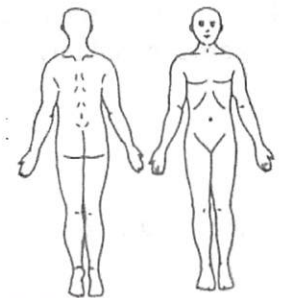
How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? No Yes **If yes**, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ N/A

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

LIST RESTRICTED ACTIVITY:

CURRENT ACTIVITY LEVEL:

USUAL ACTIVITY LEVEL:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your problem the result of ANY type of accident? Yes, No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes **If yes, how many times?** _____ **When was the last episode?** _____ **How did the injury happen?** _____

Other forms of treatment tried: No Yes **If yes, please state what type of treatment:** _____, and who provided it: _____ **How long ago?** _____ **What were the results.** Favorable Unfavorable → please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

SOCIAL HISTORY

- Smoking:** Cigars Pipe Cigarettes How often? Daily Weekends Occasionally Never
- Alcoholic Beverage:** Consumption Occurs Daily Weekends Occasionally Never
- Recreational Drug Use:** Daily Weekends Occasionally Never
- Hobbies -Recreational Activities- Exercise Regiment:** How does your present problem affect? (See ADL form)

FAMILY HISTORY:

- Does anyone in your family suffer with the same condition(s)? No Yes
If yes whom: Grandmother Grandfather Mother Father Sister(s) Brother(s) Son(s) Daughter(s)
Have they ever been treated for their condition? No Yes I don't know
- Any other hereditary conditions the doctor should be aware of? No Yes: _____

Patient or Authorized Person's Signature

_____-_____-_____
Date Completed

Doctor's Signature

_____-_____-_____
Date Form Reviewed

PATIENT'S NAME: _____

Date: _____

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.

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 - 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 upcoming 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.

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I have received a copy of the Patient Privacy Notice. I understand my rights as well as the practice's 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 a 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. 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's Signature

Date

Witness

Date



ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

Carry Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sit to Stand	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Climb Stairs	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Pet Care	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Extended Computer Use	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Lift Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Read/Concentrate	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Getting Dressed	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Shaving	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sexual Activities	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sleep	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Sitting	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Standing	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Yard work	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Walking	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Washing/Bathing	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sweeping/Vacuuming	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Dishes	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Laundry	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Garbage	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Driving	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Other:	<input type="radio"/> No Effect	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform

REVIEW OF SYSTEMS

Please mark

P for Past

C for Currently have

N for Never

- | | | |
|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Heart Burn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Double Vision | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Irritable | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Gall Bladder Problems |
| <input type="checkbox"/> Numb/Tingling Arms, Hands, Fingers | <input type="checkbox"/> ADHD | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Numb/Tingling Legs, Feet, Toes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Frequent Colds/Flu |
| <input type="checkbox"/> Impotence/Sexual Dysfunction | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Colon Troubles | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Pain with Cough/Sneeze | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> PMS | <input type="checkbox"/> Sinus/Drainage Problems |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Swollen, Painful Joints | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Trouble Sleeping |

Signature _____

Date _____

PAIN SCALE

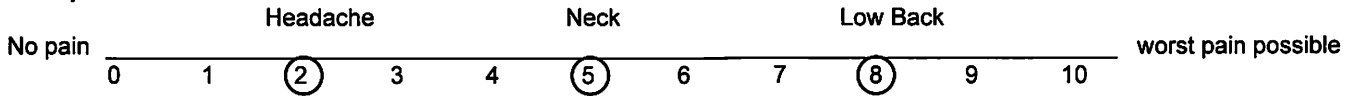
Patient Name _____ Date _____

Please read carefully:

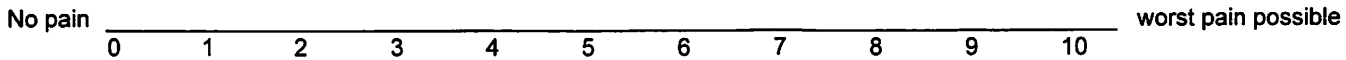
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

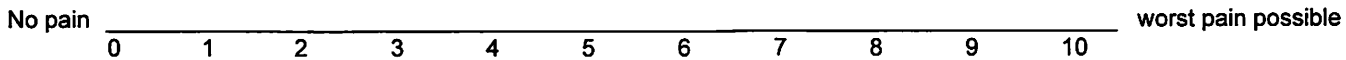
Example:



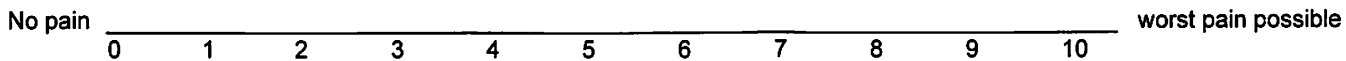
1 - What is your pain RIGHT NOW?



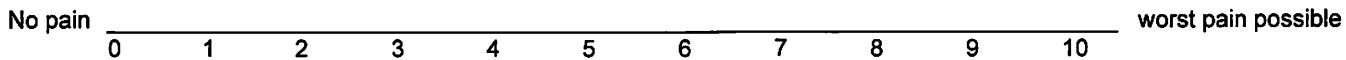
2 - What is your TYPICAL or AVERAGE pain?



3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its BEST)?



4 - What is your pain level AT ITS WORST (How close to "10" does your pain get at its WORST)?



OTHER COMMENTS:
