**Confidential Patient Health Record** ***Today’s Date*:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

*Whom may we thank for referring you?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Personal Information***

Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_ /\_\_\_\_/\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ Sex: Male / Female SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single Married Widowed Divorced Separated

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt # \_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_ Work Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_

Cell Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_ Fax #: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouses Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact

Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: Spouse Relative Friend Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

***Employment Information***

Business Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation/Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Description \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### SECTION 1 MAIN COMPLAINT/HEALTH CONDITION QUESTIONS

**Main Complaint or 1st Problem area (Where is it located?)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your problem the result of ANY type of work related or car accident?** Yes or No  **If YES, date of work injury or car accident?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe the onset (how did it this complaint happen?)\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did this problem begin (DATE THIS BEGAN)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What have you done since the onset?** Nothing Urgent Care Rest Ice Heat OTC medications RX medications Primary Care Doctor Massage Chiropractic or Physical therapy

**Describe the frequency (Choose one**): □ Constant □Frequent □ Intermittent

**How would you describe the pain (check all that apply):**  □Aching □Burning □Deep □Dull □Pulling □Sharp □Stiff □Shooting □Stabbing □Tight □Numbness □Tingling □Weakness □Other\_\_\_\_\_\_\_\_\_\_

**Does it radiate to any other locations?** Yes or No If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are headaches present?** Yes or No Describe: Tension Sinus Migraine Cluster

**On a scale of 0 to 10 (10 being the worst pain and 0 being no pain) rate your above complaints by circling the number:**

**1st complaint only:** 0 1 2 3 4 5 6 7 8 9 10

**What makes your symptoms BETTER?** Nothing Rest Ice Heat OTC medications RX medications Massage Chiropractic or Physical therapy

**What makes your symptoms WORSE?** Sitting sleeping driving standing walking lifting running any movement

**Have you experienced this condition or any other similar conditions in the PAST?** Yes or No

 **If yes, when was the last time**? \_\_\_\_\_\_\_**What treatment did you receive**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By whom**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any RECENT X-Rays, labs or diagnostic testing? Yes or No If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#####  ACTIVITIES OF DAILY LIVING – PLEASE CHOOSE NO MORE THAN 2 and DESCRIBE HOW LONG YOU CAN PERFORM BEFORE THE SYMPTOMS START

□Sleeping: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Driving: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Lifting: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Standing: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Sitting: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□OTHER\_\_\_\_\_\_\_\_\_\_ How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

**Do you have a SECOND complaint or health condition which you are now consulting us with? YES or NO**

**If yes please continue with section 2 if NO skip to REVIEW OF SYSTEMS on page 4.**

##### SECTION 2 SECOND COMPLAINT/HEALTH CONDITION QUESTIONS

**2nd Complaint area (Where is it located?)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your problem the result of ANY type of work related or car accident?** Yes or No  **If YES, date of work injury or car accident?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe the onset (how did it this complaint happen?)\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did this problem begin (DATE THIS BEGAN)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What have you done since the onset?** Nothing Urgent Care Rest Ice Heat OTC medications RX medications Primary Care Doctor Massage Chiropractic or Physical therapy

**Describe the frequency (Choose one**): □ Constant □Frequent □ Intermittent

**How would you describe the pain (check all that apply):** □Aching □Burning □Deep □Dull □Pulling □Sharp □Stiff □Shooting □Stabbing □Tight □Numbness □Tingling □Weakness □Other\_\_\_\_\_\_\_\_\_\_

**Does it radiate to any other locations?** Yes or No If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are headaches present?** Yes or No Describe: Tension Sinus Migraine Cluster

**On a scale of 0 to 10 (10 being the worst pain and 0 being no pain) rate your above complaints by circling the number:**

**2nd complaint Pain levels:** 0 1 2 3 4 5 6 7 8 9 10

**What makes your symptoms feel BETTER?** Rest Ice Heat OTC medications RX medications Massage Chiropractic or Physical therapy

**What makes your symptoms feel WORSE?** Sitting sleeping driving standing walking lifting running

**Have you experienced this condition or any other similar conditions in the PAST?** Yes or No

 **If yes, when was the last time**? \_\_\_\_\_\_\_**What treatment did you receive**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By whom**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any RECENT xrays, labs or diagnostic testing? Yes or No If yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#####  ACTIVITIES OF DAILY LIVING – PLEASE CHOOSE NO MORE THAN 2 and DESCRIBE HOW LONG YOU CAN PERFORM BEFORE THE SYMPTOMS START

□Sleeping: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Driving: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Lifting: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Standing: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Sitting: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□OTHER\_\_\_\_\_\_\_\_\_\_ How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

##### 3. REVIEW of SYSTEMS: Below is a list of symptoms that may seem unrelated to the purpose of your appointment. These questions must be answered carefully as the problems can affect your overall course of care.

***Musculoskeletal:*  🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 osteoarthritis** | **🞎 degenerative disc**  | **🞎 osteoporosis** | **🞎 joint replacement** |
| **🞎 osteopenia**  | **🞎 Rheumatoid arthr** | **🞎 degenerative disc disease** |  |

***Neurologic System:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **🞎 dizziness** | **🞎 limb weakness** | **🞎 numbness** | **🞎 slurred speech** | **🞎 tremor** |
| **🞎 facial weakness**  | **🞎 loss of consciousness**  | **🞎 seizures** | **🞎 anxiety/depression** | **🞎 loss of balance** |
| **🞎 headache**  | **🞎 loss of memory**  | **🞎 sleep disturbance** | **🞎 strokes**  |  |

***Ears, Nose and Throat:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **🞎 bleeding** | **🞎 ear drainage** | **🞎 hearing loss** | **🞎 nosebleeds** |  **sore throat** |
| **🞎 dentures**  | **🞎 ear pain** | **🞎 history of head injury** | **🞎 postnasal drip** |  **tinnitus** **(ringing in ears)** |
| **🞎 difficulty**  **swallowing** | **🞎 fainting** | **🞎 hoarseness** | **🞎 rhinorrhea** **(runny nose)** |  **TMJ problems** |
| **🞎 discharge**  | **🞎 frequent sore throats** | **🞎 loss of sense of smell** | **🞎 sinus infections** |  |
| **🞎 dizziness**  | **🞎 headaches/migraine** | **🞎 nasal congestion**  | **🞎 snoring**  |  |

*Cardiovascular:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.

|  |  |  |
| --- | --- | --- |
| **🞎 angina (chest pain or discomfort)** | **🞎 high blood pressure** | **🞎 shortness of breath**  **with exertion or exercise** |
| **🞎 chest pain** | **🞎 low blood pressure** | **🞎 swelling of legs** |
| **🞎 claudication (leg pain/ache)** | **🞎 orthopnea (difficulty breathing lying down)** | **🞎 ulcers** |
| **🞎 heart murmur** | **🞎 palpitations** | **🞎 varicose veins** |
| **🞎 heart problems** | **🞎 Pacemaker or Defibrillator** |  |

*Respiration:* 🞎 I DENY having any of the symptoms or problems listed below.

|  |  |  |
| --- | --- | --- |
| **🞎 asthma** | **🞎 coughing up blood** | **🞎 sputum production** |
| **🞎 cough** | **🞎 shortness of breath** | **🞎 wheezing** |
|  |  |  |

***Gastrointestinal:*  🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
|  **🞎 constipation** | **🞎 abdominal pain** | **🞎 indigestion/reflux** | **🞎 abnormal stool \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |  |  |  |
| **🞎 diarrhea**  | **🞎 bloating** | **🞎 nausea** | **🞎 abnormal vomiting** |
|  |  |  |  |

***Eyes/Vision:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 blindness** | **🞎 change in vision** | **🞎 field cuts** | **🞎 photophobia** |
| **🞎 blurred vision** | **🞎 double vision** | **🞎 glaucoma** | **🞎 tearing** |
| **🞎 cataracts**  | **🞎 eye pain** | **🞎 itching** | **🞎 wear glasses/contacts** |

***Endocrine:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 cold intolerance** | **🞎 excessive hunger** | **🞎 goiter** | **🞎 unusual hair growth** |
| **🞎 diabetes** | **🞎 excessive thirst**  | **🞎 hair loss** | **🞎 voice changes** |
| **🞎 excessive appetite** | **🞎 abnormal frequency of urination** | **🞎 heat intolerance** |  |

***Skin:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 changes in nail texture** | **🞎 hair loss** | **🞎 itching** | **🞎 skin lesions / ulcers** |
| **🞎 changes in skin color**  | **🞎 hives**  | **🞎 paresthesias** | **🞎 varicosities** |
| **🞎 hair growth**  | **🞎 history of skin disorders** | **🞎 rash** |  |

***Allergy:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 anaphalaxis** | **🞎 itching** | **🞎 environmental** | **🞎 animals** |
| **🞎 food intolerance** | **🞎 nasal congestion** | **🞎 rash** |  |

***Hematologic:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 anemia** | **🞎 blood clotting** | **🞎 bruising easily** | **🞎 lymph node swelling** |
| **🞎 bleeding** | **🞎 blood transfusion** | **🞎 fatigue** |  |

***Constitutional:*  🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 chills** | **🞎 fatigue** | **🞎 night sweats** | **🞎 weight loss** |
| **🞎 daytime drowsiness**  | **🞎 fever**  | **🞎 weight gain** |  |

**4. PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.**

***Current Medication (s):*  List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

|  |  |  |  |
| --- | --- | --- | --- |
|  **Medication** | **Dosage** | **For What Condition?** | **How long have** **you been taking this?**  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

***Current Illness(es):* LIST all health conditions. CIRCLE all CURRENT conditions.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 ADD/ADHD** | **🞎 cystic kidney disease** | **🞎 hypertension** | **🞎 psychiatric problems** |
| **🞎 Alzheimers**  | **🞎 depression** | **🞎 influenzal pneumonia** | **🞎 scoliosis** |
| **🞎 anemia**  | **🞎 Diabetes (insulin dep)** | **🞎 liver disease** | **🞎 seizures** |
| **🞎 arthritis**  | **🞎 Diabetes (non insulin)** | **🞎 lung disease** | **🞎 shingles** |
| **🞎 asthma**  | **🞎 eczema** | **🞎 lupus erythema (discoid)** | **🞎 past history of similar symptoms** |
| **🞎 cancer**  | **🞎 emphysema** | **🞎 lupus erythema (systemic)** | **🞎 STD’s (unspecified)** |
| **🞎 Cerebral palsy**  | **🞎 eye problems** | **🞎 multiple sclerosis** | **🞎 suicide attempt(s)** |
| **🞎 COPD** | **🞎 fibromyalgia** | **🞎 Parkinson’s disease**  | **🞎 thyroid problems** |
| **🞎 Crohn’s/colitis**  | **🞎 heart disease** | **🞎 unspecified pleural effusion**  | **🞎 vertigo** |
| **🞎 CRPS (RSD)** | **🞎 hepatitis**  | **🞎 pneumonia**  | **🞎 other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **🞎 CVA (stroke)** | **🞎 HIV** | **🞎 psoriasis** |  |

***Surgery (ies):* LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

***Injury (ies):* Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

|  |  |  |
| --- | --- | --- |
| **🞎 back injury** | **🞎 head injury (loss of consciousness)** | **🞎 motor vehicle accident** |
| **🞎 broken bones**  | **🞎 head injury (no loss of consciousness)** | **🞎 soft tissue injury (mild)** |
| **🞎 disability (ies)**  | **🞎 industrial accident** | **🞎 soft tissue injury (moderate)** |
| **🞎 fall (severe)** | **🞎 joint injury** | **🞎 soft tissue injury (severe)** |
| **🞎 fracture**  | **🞎 laceration (severe)** | **🞎 other:** |

***Family History:* Mark all that apply below. List any specific conditions past or present after has/had:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **general family** | **🞎 alive** | **🞎 deceased**  | **🞎 normally developed** | **🞎 no significant disease** |  **has/had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **father** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** |  **has/had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **mother** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** |  **has/had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **son (s)** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** |  **has/had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **daughter(s)** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** |  **has/had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **brother(s)** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** |  **has/had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **sister(s)** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** |  **has/had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

***Social History***

**Alcohol: 🞎 Never 🞎 Social Consumption only 🞎 Beer 🞎 Liquor 🞎 Wine ; \_\_\_\_\_ oz \_\_\_\_ glasses; 🞎 Day 🞎 Week 🞎 Month**

**Diet (please mark all that apply): 🞎 High Fat 🞎 High Fiber 🞎 High Protein 🞎 High Salt**

**🞎 Low Calorie 🞎 Low Carb 🞎 Low Fiber 🞎 Low Salt 🞎 Low Sugar**

**Tobacco: 🞎 Deny Tobacco Use 🞎 Do not smoke cigars, cigarettes or pipe 🞎 Live with a smoker 🞎 Quit smoking**

**🞎 Smoke; # \_\_\_\_\_\_\_\_ per 🞎 Day 🞎 Week 🞎 Month 🞎 Chew; #\_\_\_\_\_\_\_\_\_cans per 🞎 Day 🞎 Week 🞎 Year**

**Initials: \_\_\_\_\_\_\_\_ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is separate and distinct healing art from medicine and does not proclaim to cure any named disease.**

**Initials:\_\_\_\_\_\_\_\_\_\_ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

**Initials:\_\_\_\_\_\_\_\_\_\_ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Initials:\_\_\_\_\_\_\_\_\_\_ I grant permission to be called to confirm or reschedule an appointment and to be sent emails or health information to me as an extension of my care in this office.**

**Initials:\_\_\_\_\_\_\_\_\_\_ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

**Initials:\_\_\_\_\_\_\_\_\_\_ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

I acknowledge that I have received the Clinic’s Notice of Privacy Practices for protected health information.

### Patient Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Functional Rating Index**

**Today’s Date:** \_\_\_-\_\_\_-\_\_\_

**Patients Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Instructions**

We are interested in knowing whether you are having any difficulty at all with the activities listed below. Please circle **one** answer for each activity.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **0** | **1** | **2** | **3** | **4** |
| 1. **Pain**

**Intensity** | No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain |
| 1. **Sleeping**
 | Perfect Sleep | Mildly Disturbed Sleep | Moderately Disturbed Sleep | Greatly Disturbed Sleep | Totally Disturbed Sleep |
| 1. **Personal Care (washing, dressing etc.)**
 | No Pain; No Restrictions | Mild Pain; No Restrictions | Moderate Pain; Need to go Slowly | Moderate Pain; Need Some Assistance | Severe Pain; Need 100% Assistance  |
| 1. **Travel (driving, etc.)**
 | No Pain on Long Trips | Mild Pain on Long Trips | Moderate Pain on Long Trips  | Moderate Pain on Short Trips  | Severe Pain; Need 100% Assistance  |
| 1. **Work**
 | Can do Usual Work Plus Unlimited Extra Work | Can do Usual Work no Extra Work | Can do 50% of Usual Work | Can do 25% of Usual Work  | Cannot Work |
| 1. **Recreation**
 | Can do all Activities  | Can do Most Activities  | Can do Some Activities  | Can do a Few | Cannot do Any Activities |
| 1. **Frequency of Pain**
 | No Pain  | Occasional Pain; 25% of the Day | Intermittent Pain; 50% of the Day | Frequent Pain; 75% of the Day | Constant Pain; 100% of the Day |
| 1. **Lifting**
 | No Pain with Heavy Weight  | Increased Pain with Heavy Weight | Increased Pain with Moderate Weight  | Increased Pain with Light Weight | Increased Pain with Any Weight  |
| 1. **Walking**
 | No Pain; Any Distance | Increased Pain After 1 Mile | Increased Pain After ½ Mile  | Increased Pain After ¼ mile | Increased Pain with All Walking |
| 1. **Standing**
 | No Pain After Several Hours | Increased Pain After Several Hours | Increased Pain After 1 Hour | Increased Pain After ½ Hour  | Increased Pain with Any Standing  |

**ChiroSouth Spine and Sport**

**Informed Consent for Chiropractic Treatment**

You have the right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, laser and acupuncture/dry needling. The chiropractic treatment may be performed by any of the Doctors of Chiropractic working at ChiroSouth Spine and Sport. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a back up for the doctors at ChiroSouth spine and Sport.

I have had the opportunity to discuss with the doctor my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that there are some risks to chiropractic treatment including but not limited to:

* Broken bones
* Dislocations
* Sprains/strains
* Burns or frostbite (physical therapy)
* Worsening/aggravation of spinal conditions
* Increased symptoms/pain
* No improvement of symptoms or pain
* Infection (acupuncture/dry needling)
* Punctured lung (acupuncture/dry needling)
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature or representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness to patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ChiroSouth Spine and Sport**

**Authorization for Verbal Communication, to Leave Voicemail Messages, and/or Receive Emails Regarding My Personal Health Information**

This does not authorize release of medical records without a signed authorization to release medical records by patient or guardian.

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

**INFORMATION TO BE DISCLOSED:** Verbal communication only regarding patients care-no copies of medical records provided

**PLEASE PROVIDE YOUR CURRENT TELEPHONE NUMBERS WHERE WE HAVE PERMISSION TO CALL AND/OR LEAVE A CONFIDENTIAL VOICEMAIL:**

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We normally contact our patients between 8 a.m. and 5 p.m. Monday through Friday. Please check below where you would prefer to be contacted during these hours:**

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**If we need to contact you after hours, please check below where you prefer to be called:**

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**YOUR PROTECTED HEALTH INFORMATION DESIGNEES:**

If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information. This person (designee) will also be able to call the office on your behalf.

**PLEASE PRINT THE NAME AND RELATIONSHIP TO YOU/PATIENT OF EACH DESIGNEE BELOW:**

Designee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ **CHECK HERE IF YOU *DO NOT* WANT YOU HEALTH CARE INFORMATION DISCUSSED WITH ANYONE OTHER THAN YOURSELF.**

**APPOINTMENT REMINDERS:**

If you would like to be set up for appointment reminders, please list a cell phone number and provider OR email address.

**(Cell phone provider required for text reminders!)**

Cell phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR** Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONFIDENTIAL EMAIL:**

**PLEASE WRITE BELOW AN EMAIL ADDRESS THAT WE CAN SEND EDUCATIONAL INFORMATION PERTAINING TO YOUR TREATMENT PLAN/GOALS (STRETCHES, EXCERSICES, ETC.):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR SIGNATURE BELOW CONFIRMS YOUR APPROVAL OF THESE UPDATED HIPAA COMMUNICATIONS PREFERENCES. YOU MAY CHANGE YOUR SELECTIONS AT ANY TIME, BUT MUST DO SO IN WRITING BY COMPLETEING AN UPDATED FORM.**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

**OFFICE POLICY**

We believe that a clear definition of our office policies will allow YOU, the patient, and Us, the doctor, to concentrate on the big issue – **REGAINING AND MAINTAINING** **YOUR HEALTH**.

**APPOINTMENT POLICY**

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that count, not the days on which you receive the service.

**This office reserves the right to charge $70 for no call/no show appointments, as there are other patients that may need those appointment times.** If, for any reason, you are unable to keep an appointment and can’t reschedule with 24 hours’ notice, we require that you telephone immediately to reschedule that visit; we typically can fill your appointment time within at least 1 hours’ notice. If it is after office hours you may leave a message on our voicemail at 251-316-0010. If there are 3 missed appointments/no call no shows in a row you could be dismissed from care.

When entering the office on any given visit, please go directly to the front desk and “sign in”. We sincerely attempt to honor all appointments at the scheduled time. If you are more than 10 minutes late for your appointment, you may be asked to wait for the next available appointment; we cannot guarantee how long you may have to wait to be seen or which doctor will be able to see you.

**FINANCIAL POLICY**

1. It is our policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments whether or not the office accepts insurance assignment.
2. All payments are expected at the time of services or at the end of the week. Patient balances may not exceed $150.00 at any time.
3. All insurance assignment patients must pay their deductible in full and the co-pay/co-insurance at the time of service or at the end of the week.
4. There will be a $35.00 fee imposed for all checks returned to this office.

**5**. Returned checks and balances over 30 days may be subject to additional collection fees

 and interest charges of 1.5% per month. Charges may also be made for missed

 appointments and those, cancelled without a 24-hour notice.

A detailed policy manual has been given to me. I have read and understand all the policies.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ChiroSouth Spine and Sport**

**277 McGregor Ave South**

**Mobile, AL 36608**

OFFICE POLICIES

FOR PATIENTS

**APPOINTMENT POLICY**

Office visits are scheduled according to the severity of your condition and the program of chiropractic care that the doctor feels is best for you. Since your condition requires numerous appointments over the next few weeks or months, we have designed a multiple appointment program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine.

**The frequency of your visitation schedule is of paramount importance to your results, so we ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results for you.**

We also run a no wait clinic (we don’t like to make our patients wait); in order for us to continue with this benefit you need to arrive for your appointments on time.

**\*\*Missed/Rescheduled Appointments\*\***

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that count, not the days on which you receive the service. **This office** **reserves the right to charge $70 for no call/no show appointments, as there are other patients that may need those appointment times.** If, for any reason, you are unable to keep an appointment and can’t reschedule with 24 hours’ notice, we require that you telephone immediately to reschedule that visit; we typically can fill your appointment time within at least 1 hours’ notice. If it is after office hours you may leave a message on our voicemail at 251-316-0010. If there are 3 missed appointments/no call no shows in a row you could be dismissed from care.

When entering the office on any given visit, please go directly to the front desk and “sign in”. We sincerely attempt to honor all appointments at the scheduled time. **If you are more than 10 minutes late for your appointment, you may be asked to wait for the next available appointment**; **we cannot guarantee how long you may have to wait to be seen or which doctor will be able to see you.** The doctors are often requested for speaking engagements and corporate ART work and very commonly have to leave the office quickly in the afternoon. If you are running late, please contact the office immediately. We cannot ensure the doctors will be here after your scheduled appointment time. If we are unexpectedly running behind, we will try to contact you and advise you on the status of your appointment time. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

**EMERGENCY NUMBERS**

In case of non-life threatening emergencies such as flare ups, falls, or injuries, please call the office at 251-316-0010. The doctors may not be able to see you right away, but the doctor can give you recommendations until they can. Please call if any of the above occurs to you or your family.

**CELL PHONES**

Some of our patients experience migraines and/or other problems provoked by the tone of a cellphone. For this reason, we ask that you turn your cell phone to silent upon entering the office.

There is **no talking** on cell phones while in the office, especially in treatment areas, as this may interfere with our equipment and is disrespectful to the doctor treating you.

**KIDS**

We are a family oriented office, but due to the conditions we commonly treat (headaches, migraines, etc.) we ask that if your child in under 10 years of age, they are not left in the treatment areas unsupervised.

**FINANCIAL POLICY**

Patients must understand that ultimately they are financially responsible for professional services rendered. We do not bill patients. If we are forced to bill you, a $15 book keeping service fee will be added.

* It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services including those not reimbursed by third party payers.
* All payments are expected at the time of service. Patient balances are not to exceed $150.00 at any time.
* All insurance assignment patients must pay their deductibles in full and the copayments at the time of service.
* Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for missed appointments and those cancelled without 24 hours’ notice.
* All accounts not paid within 90 days will automatically be put through collections.

**CASH POLICY**

This policy is very simple-all services must be paid at the time they are rendered.

**INSURANCE POLICY**

* The privilege of insurance assignment begins when out office receives your insurance forms.
* All deductible payments MUST be made prior to insurance submittal.
* You are considered to be a cash patient until our office qualifies your coverage to determine the extent of benefits under your policy.
* All copayments are payable when the services are rendered. A $150.00 balance must not be exceeded by any patient. **Services may be declined if balance has been exceeded.**
* All patients whose visitation schedule is once per month will not be eligible for insurance assignment. Charges for services will again be due as they are received.
* Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted.
* This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.
* Since we do not own your policy and occasionally will experience difficulty in collection from the carrier, we may ask for your active assistance in rectifying this situation.