CHIROPRACTIC HEALTHPLUS / HENDRICKSON CHIROPRACTIC P.A.

Today's Date: _____ Account # _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐Male ☐Female

Name you wish to be called in our office: _____ Spouse's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone: _____ E-mail Address: _____

Home Phone: _____ Social Security #: _____

Work Phone: _____ Preferred Method of Communication: phone / email

Employer: _____ Occupation: _____

Name of Emergency Contact: _____ Ph #: _____

HISTORY of COMPLAINT(s)

Primary Problem: _____ **When did problem begin?** _____

What relieves your symptom? Rest Ice Heat Movement Stretching Other _____

_____ **What makes your symptom worse?** Rest Sit Stand Movement Overuse Stress Other_____

Frequency: Off & On / Constant **Does the pain radiate?** No / Yes **Where?**_____

_____ **How long does this problem last?** _____ **# of prior episodes?** _____

Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore

_____ On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today? _____

Secondary Problem: _____ **When did problem begin?** _____

What relieves your symptom? Rest Ice Heat Movement Stretching Other _____

_____ **What makes your symptom worse?** Rest Sit Stand Movement Overuse Stress Other_____

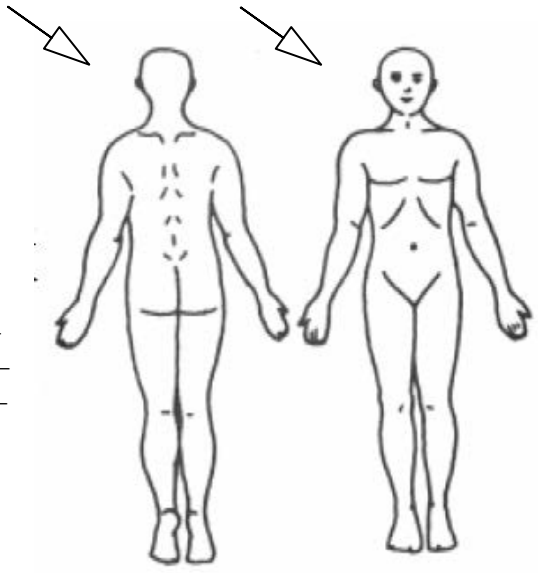
Frequency: Off & On / Constant **Does the pain radiate?** No / Yes **Where?**_____

_____ **How long does this problem last?** _____ **# of prior episodes?** _____

Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore

_____ On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today? _____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull
A = Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



Do your symptoms cause you to feel worse in the ☐ AM ☐ PM ☐ mid-day ☐ late PM
Have these Problems ever been treated by anyone in the past? ☐No ☐Yes
If yes, Who provided: _____
How long ago? _____ What **type** of treatment did you receive? _____
What were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable** please explain:
_____
List any **medications** taken to treat these conditions: _____
Did they help? ☐ No ☐ Yes If you still take them, how often? _____
Have you ever been under chiropractic care? ☐ No ☐ Yes **If yes,** how long ago: _____
Name of Previous Chiropractor: _____
Are any of your problem(s) today the result of ANY **recent accident**? ☐ No ☐ Yes
If yes, How long ago? _____
Please explain what type of accident: _____

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PAST HISTORY

1. 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 and **N** for **Never** have had:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Rheumatoid Arthritis
___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Other_____
___ Osteo Arthritis ___ Fracture ___Diabetes ___ Seizure

2. PLEASE**, identify** ALL PAST **and any** unrelated current **conditions you feel may be contributing to your present problem:**

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS			
ADULT DISEASES			
SURGERIES			
CHILDHOOD DISEASES			

Reserved for doctor's use only → Systems reviewed with patient:
❑Musculoskeletal
❑Neurological

Medications: _____

Medication Allergies: _____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. How many years of school have you completed? ❑ 1-8 ❑ 8-12 ❑12-14 ❑14-16 ❑ 16 +

FAMILY HISTORY:

1. 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)
2. Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know
3. Any other hereditary conditions the doctor should be aware of ❑ No ❑Yes _____

Whom may we thank for referring you into our office today? _____

How do you plan to take care of your charges today? ❑ Cash ❑ Check ❑ Credit Card

Informed Consent

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include, sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures. One of the rarest complications associated with Chiropractic care (occurring at a rate between one instance per one million to one instance per two million) is a cervical spine (neck) adjustment causing injury to a vertebral artery which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures enlisted by the doctor(s) in practice. This form was not signed until all my questions regarding treatment were answered to my complete satisfaction, and I conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor discussed with me that he/she deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

_____ _____ - _____ - _____
Patient/Guardian Signature Date Completed

Reviewed by: _____ _____
Reviewer Initials Doctors Initials

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Patient's Name: _____Date: _____ ACCT: _____

ACTIVITIES OF LIFE

Please identify how your current condition(s) affect your ability to carry out activities that are routinely part of your life:

Activities:	Effect:			
Carrying Groceries	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sit to Stand	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Climbing Stairs	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Pet Care	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Extended Computer Use	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Household Chores	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Lifting Children	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Reading/Concentration	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Bathing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Dressing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Shaving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sleep	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sitting Still	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Standing Still	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Yard work	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Walking	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Washing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sweeping/Vacuuming	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Dishes	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Laundry	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Exercise Routine	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Garbage	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Hobbies	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Other: _____	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform

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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 **P**ersonal **H**ealth **I**nformation. 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. Once you have read this notice please sign the bottom of this page and return to our front desk receptionist.

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 any insurance company or other available collateral source.
4. To obtain a recent address on you in the event you move and do not leave a forwarding address, we may use your 'emergency contact information' in whatever way necessary to locate you and collect any outstanding sums you may owe the practice/doctor.
5. For workers compensation purposes- to process a claim or aid in investigation.
6. Emergency- in the event of a medical emergency we may notify a family member.
7. 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.
8. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
9. For military, national security, prisoner and government benefits purposes.
10. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
11. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI.

Note: At any time, this office may update the list of ways your PHI may be used and all updates are deemed retroactive.

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
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

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call Dr. Hendrickson at (763) 682-5490. 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

I **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. My signature below is an acknowledgement that I have received a copy of Hendrickson Chiropractic PA Patient Privacy Notice and I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient: _____ DOB: _____ACCT#:_____

Patient/Guardian Signature: _____ Date: _____

Witness: _____ Witness Signature: _____ Date: _____

Chiropractic HealthPlus / Hendrickson Chiropractic P.A. Office Policy

The best doctor/patient relationship is when there is complete understanding of the treatment and financial responsibilities between the doctor and the patient. Our primary concern is being able to schedule you as required without creating a problem for you in keeping your account up to date. This will allow you to obtain the health care you need and handle your fees in a convenient manner.

Insurance

We shall assist in all possible ways in helping you process and obtain all of the benefits for which you are eligible; but, financial obligation is yours. For your own information, please check with your insurance company as to the policy benefits to which you are eligible. We will advise you to pay any amount due for the "deductible" or any other "non-covered" charges.

Medicare

Our office will submit all Medicare services to Medicare. Patients who have Medicare benefits are required to pay their portion as services are rendered. Once the annual deductible has been satisfied, the patient will be responsible for the portion not covered by Medicare.

Personal Payment

Patients who do not have Chiropractic included in their insurance coverage are expected to make payments at each visit. For your convenience we accept cash, personal checks, MasterCard, Visa, and Discover. We will be happy to discuss your financial charges. This will allow you to obtain the healthcare you need and handle your fees in a convenient manner.

Payment Agreement

I have read and understand the Office Policy as it pertains to my financial responsibility. I understand that I am responsible for any balance due at the time that services are rendered. I am aware that if my account is past due by 30 days there will be an 8% finance charge added to my balance monthly. Should collection services be required, fees for those services will be added to my balance and will be my responsibility. I also understand that I am responsible for all court costs and attorney fees should legal action be required.

Consent

I hereby authorize and release the doctor and whomever he may designate as his assistant to administer treatments, physical examinations, x-ray studies, chiropractic care, or any clinic services that he deems necessary in my case.

I agree that if I discontinue my care for any reason: 1) any time of service or other house discounts will be voided. 2) I will pay the balance in full at that time.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Date

AUTHORIZATION FOR X-RAYS (Females Only)

As of today, ____-____-____ I, _____ am certain that I am **NOT pregnant**. I have been informed that x-rays should not be taken of me if I am pregnant, as this may cause injury to the fetus.

I authorize Dr. Hendrickson to expose me to ionizing radiation as necessary for an x-ray examination.

_____ _____

Patients/Guardian Signature **Date**