Chiropractic Patient Information/History

Date_____ **(Please Print Clearly)**

Name_____ **Social Security #**_____ **Home Phone**_____

Email Address_____ **Cell Phone**_____

Can we add you to our Email/Mailing list? Y N Cell Phone Carrier _____

How were you referred to our office? _____

Address_____City_____State_____Zip_____

Age_____DOB_____Marital Status: M S W D Spouse's Name_____

Occupation_____Employer_____

Emergency Contact_____Relationship_____Phone_____

HEALTH INSURANCE INFORMATION (Please check any and all insurance that may be applicable in this case)

Major Medical_____Worker's Compensation_____Medicaid_____ Medicare_____ Auto accident_____

Medical Savings Account and Flex Plans_____Other_____No Insurance_____

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians' and other healthcare providers and payors and to secure payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Patient's Signature:_____Date:_____

Guardian's Signature Authorizing Care_____Date:_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint/Purpose of this Appointment:_____

_____

_____

Date symptoms appeared or accident happened:_____

Pain Level at its worst (circle one): Least Pain 1 2 3 4 5 6 7 8 9 10 Most Pain

Is this due to: Auto Accident_____ Work Injury_____ Other _____

Have you ever had the same or similar condition? Yes _____No _____If yes, when and describe:_____

_____

What doctors have you seen for this condition?_____

Do you have a history of stroke or hypertension?_____

Have you had any major: Illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates):_____

_____

Have you been treated for any health condition by a physician in the last year? Yes_____No_____

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you currently take any supplements or vitamins? Yes_____No_____

If yes, describe:_____

Do you have any allergies of any kind? Yes_____No_____

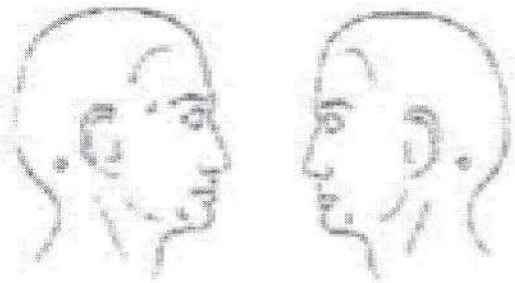
If yes, describe:_____

Women: Are you pregnant? Yes_____No_____

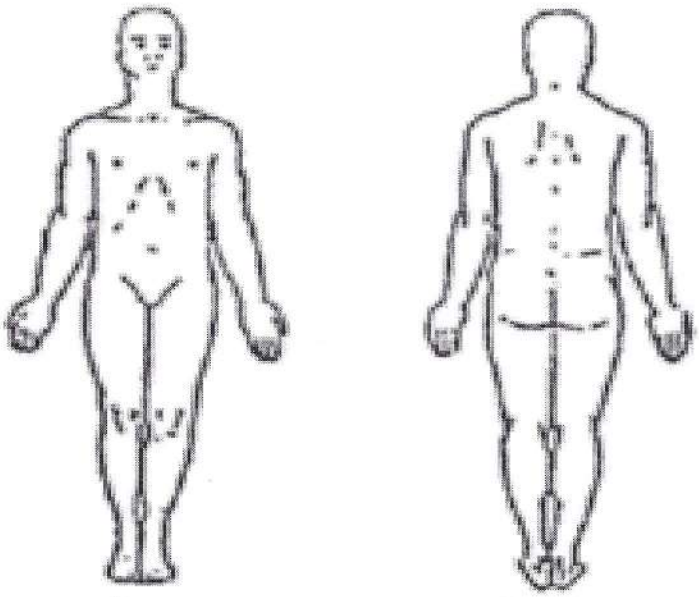
I certify the information given is correct to the best of my knowledge. I will not hold my doctor or his/her staff responsible for any errors or omissions I may have made in the completion of this form.

Name_____Date_____

SUBJECTIVE PAIN ASSESSMENT



Right Left



From Back

RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A= Ache

B= Burning

ST= Stabbing

SP= Spasm

N= Numbness

P= Pains and Needles

T= Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

0	1	2	3	4	5	6	7	8	9	10	10+
NONE			LITTLE			MEDIUM			SEVERE		EXCRUCIATING

_____ _____

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE DATE

Body & Spine Solutions

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature of Patient Date