Patient Acknowledgement or Receipt
Of the
Notice of Privacy Practices

Highland Wellness Center
5606 Wilson Mills Rd.
Highland Heights, OH 44143

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

By signing this document, I acknowledge that you have a provided me with a copy of your *Notice or Privacy Practices*. The *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Date_____ Referred by _____

Cell phone _____

Name _____Home phone _____

Last *First* *Middle* Email_____

Address _____ City/ State/ Zip _____

DOB _____Sex _____ SS# _____ Marital Status M S D W

Contact Friend/ Relative _____ Phone _____

Address _____ City/ State/ Zip _____

Name of Employer _____

Address _____ City/ State/ Zip _____

Phone _____ Position _____

Spouse's Name _____ Phone _____

Name of Employer _____

Address _____ City/ State/ Zip _____

Phone _____ DOB _____

Primary Care Provider _____ Phone _____

PLEASE READ & SIGN

Failure to cancel appointments without 24-hour notice will result in full appointment fee.

If my insurance covers a portion or none of my medical bills incurred at this office, I understand that I am responsible for the balance due. If my insurance benefits have been utilized or utilized else where, I understand that I am responsible for all accruing charges.

Signature *Date*

I authorize release of any medical information necessary to process any insurance claims.

Signature *Date*

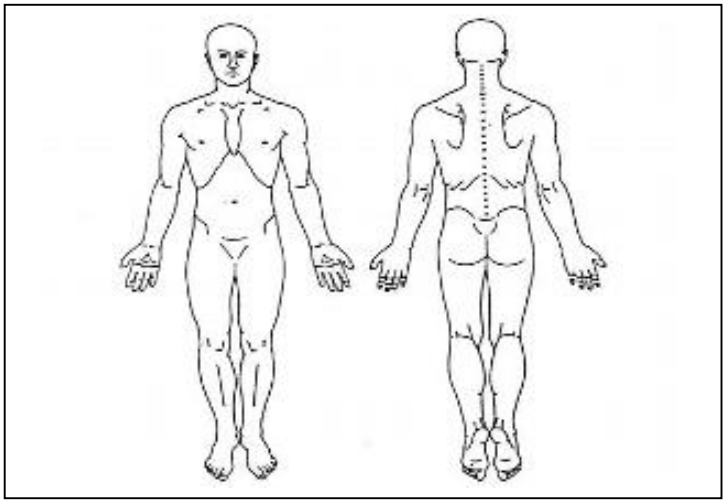
NAME_____DATE_____

	PROBLEM #1	PROBLEM #2
List and describe major problems in order of importance.		
When did it occur? Date?		
Accident related? Give details.		
What makes it better? (Medications, position, hot, cold, etc.)		
What makes it worse?		
Have you had this before? When?		
Have you seen another physician for this problem? Who?		
Were X-rays taken? Of what?		

Were you disabled from work? Y N Date last worked? _____Date Returned to work?_____

Please describe pain and location on the diagram.

Ache	Burn	Numbness	Pins & Needles	Stabbing	Other
XXX	ZZZ	OOO	. . .	/////	***



Place an "X" through the line indicating your current level of pain.

No Pain 0---1---2---3---4---5---6---7---8---9---10 Worst Possible Pain

NAME _____ Date _____

PERSONAL HISTORY

Mark the box with an X if it applies to you & circle the appropriate symptom. Explain all YES answers with dates (month & year).

Has any blood relative ever had:

- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Kidney Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Problems
- ☐ Cancer
- ☐ Hypoglycemia

Have you ever had problems with:

- ☐ Weight Change, gained or lost in past 5 years
- ☐ Fever, chills, sweats
- ☐ Allergy, Aslhma
- ☐ Anemia, Bleeding or bruising
- ☐ Thyroid Problems, Heat or cold intolerance
- ☐ Diabetes
- ☐ Eye problems (glasses, glaucoma etc.)
- ☐ Ear problems (ringing, deafness, ear infections)
- ☐ Nose/Throat problems (sinis, nosebleeds, hoarseness)
- ☐ Dizziness
- ☐ Jaw (TMJ) or dental problems
- ☐ Nausea or Vomiting
- ☐ Stomach Problems (ulcer, indigestion, heartburn, Hiatal hernia)
- ☐ Abdominal pain or swelling
- ☐ Diarrhea or constipation

How often do you have a bowel movement?

- ☐ Tarry black stool or blood in stool
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Liver or Gall Bladder problems
- ☐ Pancreas
- ☐ Do you drink alcohol?

How much?

- ☐ Shortness of breath, wheezing
- ☐ Lung problems (coughing, phlegm blood, infection, pneumonia) Tuberculosis?
- ☐ Do you smoke? How many years? How many packs?
- ☐ Occupational or Environmental Inhalation
- ☐ Heart problems
- ☐ Chest pain
- ☐ Palpitations in the heart
- ☐ High Blood Pressure
- ☐ Rheumatic fever

NAME _____ Date _____

- [ ] Urinary problems (Frequent, painful, or dribbling urination)
- [ ] Blood in Urine
- [ ] Bladder or Kidney problems
- [ ] Sexually transmitted diseases
- [ ] Testicle mass or pain
- [ ] Breast lump, pain or nipplc discharge

FOR FEMALES:

- [ ] Menstral problems
- [ ] Pelvic pain, vaginal discharge
- [ ] Ovarian cyst
- [ ] Menopause , At what age?

Menstrual flow: How many days? How many days between periods?
Date of last period
Date of last PAP?

- [ ] Skin itching or rash
- [ ] Skin Cancer
- [ ] Headaches
- [ ] Seizures
- [ ] Head trauma
- [ ] Stroke
- [ ] Joint pain, swelling or stiffness
- [ ] Neck Pain
- [ ] Upper back pain
- [ ] Low back pain
- [ ] Arm or leg problems
- [ ] Fractures, dislocations, or sprains
- [ ] Car accidents, falls or injuries
- [ ] Drug abuse
- [ ] Pyschiatric problems, anxiety, depression
- [ ] Shoe lift or insert
- [ ] Poor sleep quality. How many hours per night?

List all hospitalizations, surgeries, diseases with date:

List current medications & vitamins/supplements:

Financial Responsibility

Payment is due at the time of service unless prior arrangement has been made with our billing department.

- We accept cash, Visa, Mastercard, American Express or Discover.
- We will process your insurance forms upon receipt of your insurance card (copy).
- You will be responsible for meeting your deductibles, co-pays or costs of non-covered services at the time of visit.
- Returned checks and balances due over 30 days will be subject to collection fees and interest charges of **3.0% per month**.
- Your insurance is a contract between you, your employer and your insurance company.
- Our fees are considered usual, customary and reasonable. (UCR)
- Insurance coverage vary widely. We are participating providers for most insurance companies including Cigna, Aetna, Emerald, Medical Mutual, United Healthcare, Humana, PHCS and Medicare, we are not participating in any HMOs. Most insurance companies cover chiropractic, however deductibles and co-pays do vary.

Failure to cancel appointments without 24 hour notice will result in full appointment fee.

I have read and agree to the above terms.

Signature_____Date_____

WORK / COMP HISTORY

Name_____ Phone ( )_____

Address_____ City_____ State_____ Zip_____

Age_____ Birthday_____ Sex_____ S/S #_____

Name of Compensation Carrier:_____ Phone ( )_____

Address of Carrier:_____ City_____ State_____ Zip_____

Employer's Name:_____ Phone ( )_____

Employer's Address:_____ City_____ State_____ Zip_____

1. Type of Business_____ Your Occupation _____
2. Date Injured_____ Hour____ AM/PM Last Date Worked_____ Are you off work? ( )Yes ( ) No
3. Previous Workers' Compensation Injury? ( ) Yes ( ) No
4. Accident reported to employer? ( ) Yes ( ) No Name of person reported accident to _____
5. Injured at:_____ City_____ State_____ Zip_____
6. Length of time worked there prior to accident:_____
7. Type of work being done at time of injury:_____

_____

8. In your own words, please describe accident:_____

_____

_____

_____

9. Have you been treated by another doctor for this accident? ( ) Yes ( ) No

   If yes, please list doctor's name and address:_____

_____

What type of treatment did you receive?_____

How long were you treated by this doctor?_____

10. Are you: ( ) improved ( ) unchanged ( ) getting worse
11. What types of medicines are you taking?_____

_____

12. Have you had physical therapy? ( ) Yes ( ) No If yes, how often?

    ( ) Daily ( ) Every other day ( ) Weekly ( ) Every other week ( ) Monthly

    ( ) Several times a week ( ) Other_____

    Does the physical therapy help? ( ) Yes ( ) No ( ) Don't Know

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now? ( ) Yes ( ) No ( ) Don't know

If yes, describe:_____

_____

_____

Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No

Please provide details of accident(s):_____

_____

_____

14. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No

Describe:_____

15. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No

Describe:_____

_____

_____

16. Have you had any surgeries? ( ) Yes ( ) No

If yes, list type of surgery and date:_____

_____

_____

17. Have you had any nervous or mental illnesses? ( )Yes ( ) No

Have you had psychiatric care? ( ) Yes ( ) No

18. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

19. Have you returned to work since this accident? ( ) Yes ( ) No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: ( )low back ( )mid back ( )upper back
2. My pain began: ( )gradually ( )suddenly
3. I have pain: ( )sometimes ( )all of the time
4. My pain goes into my: ( )right leg ( )left leg ( )both
5. I have tingling and/or numbness in my: ( )right leg ( )left leg ( )both
6. My pain is worse when I:
   - Cough or sneeze ( )Yes ( )No
   - Sit ( )Yes ( )No
   - Bend ( )Yes ( )No
   - Walk ( )Yes ( )No
   - Lift ( )Yes ( )No
   - Push ( )Yes ( )No
   - Pull ( )Yes ( )No
7. My back is worse with sexual activity ( )Yes ( )No
8. My pain wakes me up during the night ( )Yes ( )No
9. Changes in the weather affect my pain ( )Yes ( )No

NECK PAIN:

1. My neck pain began: ( )gradually ( )suddenly
2. I have pain: ( )sometimes ( )all of the time
3. My pain goes into my: ( )right arm ( )left arm ( )both
4. I have tingling and/or numbness in my: ( )right arm ( )left arm ( )both
5. My pain is worse when I:
   a. Cough or sneeze ( )Yes ( )No
   b. Bend forward ( )Yes ( )No
   c. Lift ( )Yes ( )No
   d. Push ( )Yes ( )No
   e. Pull ( )Yes ( )No
   f. Turn my head ( )Yes ( )No
6. My pain wakes me up during the night ( )Yes ( )No
7. Changes in the weather affect my pain ( )Yes ( )No
8. I have neck stiffness ( )Yes ( )No
9. I have headaches ( )Yes ( )No

10. If I do get headaches, they occur: ( )sometimes ( )all of the time

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition: _____

_____

_____

_____

JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing / Pulling	( )	( )	( )	( )

3. On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( )Yes ( )No

5. Are your feet used for repetitive movements, such as in operating foot controls? ( )Yes ( )No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right hand	( )Yes ( )No	( )Yes ( )No	( )Yes ( )No
Left hand	( )Yes ( )No	( )Yes ( )No	( )Yes ( )No

7. Are you required to work on unprotected heights? ( )Yes ( )No

   Describe:_____

   _____

   _____

8. Are you required to be around moving machinery? ( )Yes ( )No

   Describe:_____

   _____

   _____

9. Are you exposed to marked changes in temperature and humidity? ( )Yes ( )No

   Describe:_____

   _____

   _____

10. Are you required to drive automotive equipment? ( )Yes ( )No

    Describe:_____

_____

_____

11. Are you exposed to dust, fumes and/or gases? ( )Yes ( )No

    Describe:_____

    _____

    _____

12. Please list any additional comments: _____

    _____

    _____

    _____

    _____

Signature: _____ Date: _____