Welcome To Our Office!

8930 Brecksville Rd
Breckville, OH 44141

Confidential Health History

Date: ________________________

Name____ Date of Birth ______________________ Age _________
Address____City____________________ State_______ Zip_________
SS#________-________-________ Male / Female Email Address ____
Please check the following if interested in receiving appointment reminders: ☐ Email ☐ Text Cell Phone Carrier:__________________________
Cell Phone # ________________________________ Home Phone # _______________________________

Occupation__________________________ Employer______________________________ Work # __________________
Employer's Address____
City____________________________________ State___________ Zip Code___________________________
___ Married ___ Single Spouse's Name_____________________________________
Primary Insured's Name____ Insured's DOB_________________
How Many Children Do You Have? __________ Children's Ages ____________________________
Emergency Contact Name_____________________________________ Phone # _____________________________
Who Referred You To Our Office? ____

What Is The Reason For Your Visit?
Please list any recent accidents or falls: ___ Car Accident ___ Work Injury ___ Other ____________________________

What is your primary complaint? ____
How long have you been experiencing this problem? ____
On a scale of 1-10, how severe is it at its worst? 1 2 3 4 5 6 7 8 9 10
I Have ___ Been Hospitalized ___ Been Seen By Another Doctor ___ Never Received Treatment For This Problem

Is there a secondary complaint? ____
How long have you been experiencing this problem? ____
On a scale of 1-10, how severe is it at its worst? 1 2 3 4 5 6 7 8 9 10
I Have ___ Been Hospitalized ___ Been Seen By Another Doctor ___ Never Received Treatment For This Problem

Have You Ever Received Chiropractic Care? ☐Yes ☐No Last Visit Date?_________________________________
Please List Over The Counter Medications, Dosage and Frequency
____

Please List Your Current Prescription Medications
____ ____
____ ____

Do You Drink Alcoholic Beverages? ☐Yes ☐No How many drinks per week? ___ 1 - 4 ___ 5 - 10 ___ +10
Do You Smoke? ☐Yes ☐No How Much? ___ 1pack/day or less ___ More than a pack/day
Do You Exercise? ☐Yes ☐No How Often? ___ Less than 1x/wk ___ 2-3x/wk ___ More than 3x/wk
Do You Have Any Allergies? (Specify)____
Are You Pregnant? ☐Yes ☐No ☐Not Sure Date of Last Period / Due Date?______________________________

Past and Present Medical History

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Patient Name _______________________________ Date _____________

Please place a "C" next to Current symptoms. Mark "P" next to symptoms you have had in the Past.

Musculoskeletal:

___ Arthritis
___ Fracture
___ Gout
___ Hip Disorder
___ Plates/Pins/Screws
___ Implants
___ Osteoporosis
___ Red/Swollen Joints
___ TMJ issues

Neurological:

___ Difficulty concentrating
___ Dizziness
___ Epilepsy
___ Seizures
___ Loss of smell or taste
___ Headache
___ Memory issues
___ Numbness
___ Pins and Needles
___ Sleeping issues
___ Loss of vision or hearing
___ Stroke
___ Weak muscles

Head & ENT:

___ Blurred or double vision
___ Chronic ear infections
___ Cataracts
___ Difficulty swallowing
___ Ear or hearing problems
___ Glaucoma
___ Headaches or Migraines
___ Hoarseness
___ Sinus trouble
___ Recent hearing loss
___ Ringing in the ears
___ Sore throat
___ Swollen lymph nodes

Cardiovascular:

___ Blood clots
___ Chest pain or tightness
___ Heart attack
___ Heart defects
___ Coronary artery disease
___ Heart murmur
___ Difficulty breathing
___ Excessive bruising
___ Varicose veins
___ High blood pressure
___ High Cholesterol or Triglycerides
___ Low blood pressure
___ Palpitations
___ Swollen legs or feet
___ Rheumatic fever

Respiratory:

___ Apnea
___ Asthma
___ Coughing blood
___ Emphysema
___ Persistent cough
___ Pneumonia
___ Shortness of breath
___ Tuberculosis
___ Wheezing

Gastrointestinal:

___ Abdominal pain
___ Black or bloody stool
___ Bloating
___ Changes in bowel habits
___ Colon cancer or colon polyps
___ Colitis
___ Constipation
___ Crohn's disease
___ Food sensitivities
___ Gastric reflux
___ Ulcer
___ Hemorrhoids
___ Irritable bowel syndrome
___ Jaundice
___ Liver disease
___ Nausea or vomiting
___ Pancreatitis
___ Severe diarrhea

Genitourinary:

___ Blood in urine
___ Incontinence
___ Kidney stones
___ Painful or frequent urination
___ Sexual dysfunction
___ Urinary infections

Endocrine:

___ Cushing's syndrome
___ Diabetes
___ Excessive thirst
___ Heat or cold intolerance
___ Pancreatic conditions
___ Increase urination
___ Steroid treatments
___Testosterone deficiency
___ Thyroid problems

Dermatological:

___ Change in hair or nails
___ Bruise easily
___ Eczema
___ Excessive acne
___ Excessive hair loss
___ Rashes
___ Hyper/hypo pigmentation
___ Psoriasis
___ Skin cancer

Surgical and Family History

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Patient Name ________________________________ Date ________________

Past Surgical History

(Please list the year of surgery and use the additional lines as necessary)

_______ Knee arthroscopy (R/L) _______ Shoulder arthroscopy (R/L) _______ Thyroid
_______ Spine surgery (neck/back) _______ Joint replacement _______ Hernia repair
_______ Bypass (Heart or Limb) _______ Cardiac catheterization _______ Hysterectomy
_______ Ligament repair/replacement _______ Pins/Plates/Screws _______ Injections

Please list any other surgery you may have had in the past not listed above: ____________________________
____
____
____

Family History

(Please check all that apply to your family)

____ Bleeding disorder ____ Coronary artery disease ____Hepatitis
____ Cancer ____ Heart Disease/Attacks ____Seizures
____ Lung Disease ____ Rheumatoid arthritis ____Kidney disease

Please list any other disease that a member of your family may have that is not listed above: ______________
____
____
____

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Patient Bill of Rights

The Patient has the right to accurate and easily-understood information about their health plan, health care professionals, and health care facility. If there are any confusions or misunderstandings, help will be provided.

If the Patient has severe pain, an injury, or sudden illness that makes them believe that their health is in danger, the Patient has the right to be screened and stabilized using emergency services.

The Patient has the right to know their treatment options and take part in decisions about their care. Parents, guardians, family members, or others that they choose can speak for them if they cannot make their own decisions.

The Patient has a right to considerate, respectful care from their doctor, health plan representatives, and other health care providers that does not discriminate against them.

The Patient has the right to talk privately with health care providers and to have their health care information protected. The Patient also has the right to read and copy your own medical record.

The Patient has the right to a fair, fast, and objective review of any complaint there is against the health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of health care facilities.

By signing this Bill of Rights you agree that there is an understanding of the above statements.

Patient Signature: ___________________________________ **Date:** _______________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

A Notice of Privacy has been made available to me by Brecksville Physical Medicine. This describes how my health information may be used or disclosed and my rights under the Health Insurance Portability and Accountability Act (HIPAA).

By signing this authorization you acknowledge and agree that Brecksville Physical Medicine may use or disclose medical records for the purpose(s) of receiving payment, insurance benefits, insurance denials, insurance audits, intent to reconcile account, intent to help patient and training purposes.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient Signature ______________________________________ **Date** _________________
Would you like a copy of the Privacy Notice (4 pages)? ______ Yes ______ No

Optional: In addition I would like to give my consent for release of health or financial information to the following individual (this does not include copies of medical records or reports):

Name _______________________Relationship _______________Date of birth ____________

Patient Signature ____ Date _________________

CONSENT FOR TREATMENT / FINANCIAL POLICY

I ___________________________________(print name) do hereby agree and give my consent for Brecksville Physical Medicine to perform diagnostic procedures, render medical care and treatment judged medically necessary by our physicians.

I understand and agree that health and accident insurance policies are an arrangement between insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credit to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature ____ **Date** ________________

Consent to treat a minor

Patient Name: ____

Guardian Name: ______________________________________

Guardian Signature: ____________________________________ Date ______________