Radiant Health Chiropractic

715.838.9432

CONFIDENTIAL PATIENT INFORMATION

(Please Print)

Name____ Date___________

First M.I. Last

Present Address____

Street City State Zip

Permanent Address____

Street City State Zip

Home Phone (___) ____________Work Phone (___) _____________ Cell Phone (___) _____________

Age ______ E-mail address ___________________________________ Marital Status: M S W D

Birth Date ________ Number of children ____ Pregnant: Yes__ No__ Height ____ Weight ______

Employer ________________________________ Occupation ________________________________

Spouse/Guardian Name___________________Emergency contact name/number _________________

Spouse Employer/Occupation ____

Do you have insurance that covers Chiropractic care? Yes __ No __ Medicare coverage? Yes __ No__

Name of person financially responsible for this account _____________________________________

Name of Insurance Company ___________________Policy/group number ______________________

Subscriber's name ________________________________ Relationship to patient _______________

Subscriber's birth date ___________

WHO MAY WE THANK FOR REFERRING YOU? ____

HEALTH CONCERNS (Tell us why you're here)

List health concerns according to their severity	Rate of severity 1= mild 10= worst imaginable	Date started, for how long?	If you had the condition before, when?	Did problem begin with an injury?	% of time pain is present

1. ____

2. ____

3. ____

4. ____

What have you done on your own for this condition? Was it of benefit?
____
____

Is this condition interfering with your: work ___ sleep ___ daily routine ___ exercise ___ other ___

What activities aggravate your condition? ____

Have you seen a Chiropractor in the past?

"Limited Scope" Chiropractor (Focuses mainly on neck and back pain)_________________________

"Wellness" Chiropractor
(focuses on health and well being as well as underlying cause of pain and health concerns)__________

Did they take spinal x-rays? _________ When? ______________ Where? __________________

Other Doctors seen for this condition:

1. Name/Address: ____
When: _____________________ What did they say was wrong? __________________________
What did they do: ____ Did it help? ___________

2. Name/Address: ____
When: _____________________ What did they say was wrong? __________________________
What did they do: ____ Did it help? ____________

Are you unable to do certain activities that you would like to do because of this pain, illness, condition (i.e. sports, walk, pick up grandchildren, etc.)? If so, what? ________________________________
____

Have you had any surgery?
1. Type ___________________________________ When _________ Doctor ________________
2. Type ___________________________________ When _________ Doctor ________________
3. Type ___________________________________ When _________ Doctor ________________

Accidents and/or injuries: auto, work related, or other? (Especially those related to your present problems)

1. Type ____________________________________ When _______________ Hospitalized? ____
2. Type ____________________________________ When _______________ Hospitalized? ____
3. Type ____________________________________ When _______________ Hospitalized? ____

Mark the following conditions you may have had or have now (- have had, + have now):

___ Allergy	___Diarrhea	___ Eczema	___ Stroke
___ Sinus Problems	___ Constipation	___ Pneumonia	___ Low Blood Sugar
___ Ringing in Ears	___ Asthma	___ HIV (Aids)	___ Arteriosclerosis
___ Heart Disease	___ Heart Attack	___ Arthritis	___ Headaches
___ Migraines	___Thyroid Problems	___ Diabetes	___ Back Pain
___ Ulcers	___ Cancer	___ Depression	___ Neck Pain
___ High Blood Pressure	___ Irregular Periods	___ Menstrual Cramps	

___Other (please explain) ____

CURRENT MEDICINE(S) and SUPPLEMENTS

Please list ALL drugs you currently take or have taken in the past 6 months:

Name ____________________________ Dosage ______________ For what? ____________________
Name ____________________________ Dosage ______________ For what? ____________________
Name ____________________________ Dosage ______________ For what? ____________________
Name ____________________________ Dosage ______________ For what? ____________________
Name ____________________________ Dosage ______________ For what? ____________________
Name ____________________________ Dosage ______________ For what? ____________________

Please list ALL nutritional supplements, vitamins, homeopathic remedies you presently take:

Name ____ For what? ____________________
Name ____ For what? ____________________
Name ____ For what? ____________________
Name ____ For what? ____________________
Name ____ For what? ____________________
Name ____ For what? ____________________

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being? YES ____ NO ____ MAYBE ____

If dietary changes are indicated would you be willing to make changes in your diet?
YES ____ NO ____ MAYBE ____

DIET

Please grade the dietary selections that are appropriate for you according to the following scale:

D - Consume this daily **M** - Consume this monthly
W - Consume this weekly **O** - Do not consume this

_____Alcohol _____Artificial Sweetener _____Soda _____Coffee

_____Tobacco _____Diet Food _____Diet Soda _____Refined Sugar

How do you grade your physical health?
Excellent ___ Good ___ Fair ___ Poor ___ Getting better ___ Getting worse ___

How do you grade your emotional/mental health?
Excellent ___ Good ___ Fair ___ Poor ___ Getting better ___ Getting worse ___

What is your favorite Hobby? ____

Print Patient Name ____ **Date** __________________

Signature of Patient or Guardian ____

PATIENT HEALTH INFORMATION CONSENT FORM

Radiant Health Chiropractic
115 9th Avenue, Eau Claire, WI 54703

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our *Privacy Notice,* please understand that we have and always will respect the privacy of your health information. At your request, we will give you a copy of our complete *Privacy Notice.* Radiant Health Chiropractic does reserve the right to change our privacy practices as described in this notice. If any future changes are made to our privacy practices, we will notify you in writing.

Consent for Use or Disclosure of Health Information

The following are possible circumstances in which we may have to use or disclose your PHI (Patient Health Information):

- We may have to disclose your PHI to another health care provider or hospital if it is necessary to refer you to them for diagnosis assessment or treatment of your health condition.
- We may have to disclose your PHI and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your PHI within our office for quality control or other operational purposes.

Initials:______

Appointment Reminders and Health Care Information Authorization

Authorized staff of Radiant Health may need to use your name, address, phone number, billing information and your clinical records to contact you with appointment reminders, information about treatment alternatives or other PHI. We often will text from our personal cell phone(s) for reminders or scheduling. If this contact is made by phone and you are not home, a message will be left on your answering machine or voice mail. By signing this form, you are giving us authorization to contact you in these manners. As well, you may restrict the individuals or organizations to which your PHI is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office. We will not be able to honor your revocation request if we have already released your PHI before we receive your request to revoke your authorization. In addition, your authorization to give us your PHI allows us to disclose that information to your insurance company for benefit verification or claims processing. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you but it may affect reimbursement by your insurance company.

Permission to call you at work: Yes ___ No ___ Initials:______
Permission to text you from our cell phone: Yes____ No _____ Initials: _______

Wisconsin Chiropractic Association Authorization (WCA)

Authorized staff of Radiant Health may also need to disclose your name, address, phone number, billing information and your clinical records to the WCA. Due to possible problems with improper insurance claims processing or for assistance in receiving reimbursement for our services to you, your PHI may need to be disclosed to the WCA with your authorization. By signing this form, you are giving us authorization to send the WCA your PHI. You are also giving the WCA authorization to re-disclose your information to the party responsible for the payment of your services, the WCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf. You may restrict the individuals or organization to which your PHI is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office. We will not be able to honor your revocation request if we have already released your PHI before we receive your request to revoke your authorization. You have the right to refuse to give us this authorization. If you do not give us authorization it will not affect the treatment we provide or the methods we use to obtain reimbursement for your care.

Initials:______

Marketing Authorization

From time to time our office may mail you information to make you aware of special offers related to products, services and events that may interest you. Your authorization is required to provide the following products and/or services to you: birthday cards, congratulation cards, food drives, newsletters, coupons, coupon books, brochures, surveys, etc.

Initials:______

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules. This notice is effective as of ____________ and will expire seven years after the date on which you last received services from us

Initials______

I authorize you to use or disclose my health information in the manner described above. I have read this consent form and also agree I am acknowledging that I have received a copy of this consent form.

____

Patient Name (Signature) Patient Name (Printed) Date

____

Authorized Provider Representative (Signature) Date

I refuse a copy of this form at this time. Initials ______