CONFIDENTIAL PATIENT HEALTH HISTORY - UPDATE

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Preferred Name**: _____

IF CHANGED SINCE LAST VISIT:

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

Home: _____ **Mobile**: _____ **Mobile Carrier**: _____ **Work**: _____

Email: _____ **Marital Status**: Married / Single / Other

Best way to reach you: home / cell / work / email

Preferred patient reminders: email / text Occupation: _____ Employer: _____

EMERGENCY CONTACT INFORMATION

Full Name: _____

Home: _____ **Mobile**: _____

Relationship: Child / Parent / Spouse / Other: _____

Name of Previous Chiropractor: _____

Date of Last Chiropractic Adjustment: _____

Primary Care Physician: _____

Doctor's Phone: _____

FINANCIAL INFORMATION -- ***Please allow our staff to photocopy your insurance card.***

Texas State law requires that we inform you in writing of your charges at each visit. Please initial below indicating your choice of receiving a paper receipt detailing the charges for each visit.

_____ **Yes**, I would like a printed Appointment Receipt at each visit. I understand that it is my responsibility to request this at check out.

_____ **No**, I do not wish to receive any of my printed Appointment Receipts. I understand that I may request any Appointment Receipt for any date of service at any point in the future.

List all medications, Dosage and Frequency (i.e. 5 mg once a day, etc.) *Did you bring a list? Can we make a copy?*

_____

_____

_____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Describe Major Complaint for seeking care today: _____
Onset of Symptoms: _____ Describe how it began: _____

_____

Grade Intensity/Severity of Complaint: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6)
Moderate-Severe (6-8) Severe (8-10)

Is the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numb / Other: _____

How frequent is the complaint present? Come & Go / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

How does this condition affect your daily activities? *(Describe)* _____

Have you received any prior treatment for this condition?

DC / MD / PT / Massage / ER / Other: _____ Where? _____

Surgery? *(Describe)* _____

Medications? OTC / Prescriptions *(Describe)* _____

Diagnostic testing? X-rays / MRI / CT / Other: _____ When and Where? _____

❑ Acupunture ❑ Massage ❑ Other: _____

Describe any Secondary Complaints: _____

HEALTH HISTORY SINCE LAST VISIT *(PLEASE USE REVERSE SIDE OF PAGE IF NEEDED)*

MEDICATION:

Allergies to Medications: *(List and reactions)* _____

_____

_____

Vitamins & Supplements: *(List all and frequency)* _____

_____

_____

RECENT HEALTH HISTORY:

Surgeries – Date, Type and Reason: _____

_____

_____

Major Injuries/Traumas:

_____

_____

_____

Major Hospitalizations including year:

_____

_____

_____

SOCIAL AND OCCUPATIONAL HISTORY:

Lifestyle: *(Your Hobbies, Rec. Activities, Exercise, Diet, Health Goals)*

_____

_____

_____

_____

Habits:

Cigarettes – (#/day) _____
Alcohol – (amount/day) _____
Coffee/Tea – (cups/day) _____
Rec. Drugs: (list) _____

Patient or Guardian Signature _____ **Date** _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back			
No pain												**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**		

---

1 – What is your pain RIGHT NOW?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

2 – What is your TYPICAL or AVERAGE pain?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) CONSENT FORM

RELEASE OF INFORMATION: Your Protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this Consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCATION OF CONSENT: You may revoke this Consent to the use and disclosure of your PHI. You must revoke this Consent in writing. Any use or disclosure that has occurred prior to the date on which your revocation of consent is received will not be affected.

CLINICAL SUMMARY REPORT (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Next Level Chiropractic to save these electronically for me and not print them out after each visit. I understand that, upon my request, these reports are available to be printed or emailed to me for review.

I, _____ (print name), acknowledge that I have reviewed the above information and __ **DO** (or) __ **DO NOT** authorize this office to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for the purposes of processing my claim for benefits and payment of services rendered to me. I do understand that if I choose to refuse release of this information, my PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Signature of Patient/Guardian _____ **Date**_____

ASSIGNMENT OF BENEFITS/ASSIGNMENT OF CAUSE OF ACTION/CONTRACTUAL LIEN

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Your insurance should pay claims within 30 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier.

IRREVOCABLE ASSIGNMENT OF RIGHTS: I hereby assign the exclusive irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request. To any insurance company providing benefits or settlement of a claim, for any treatment rendered by this facility/physician within 15 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate check to pay in full all services rendered by this office.

I instruct checks to be made payable to Next Level Chiropractic, and payment to be sent to 554 W Ralph Hall Pkwy, Rockwall, TX 75032

This demand specifically conforms to Sec. 542.057 of theTexas Insurance Code and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s). I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by this facility/physician, in addition to reasonable cost of collection, including attorney fees and court costs incurred.

LIMITED POWER OF ATTORNEY: I hereby grant the above named facility/physician the power to endorse my name upon any checks drafts, or other negotiable instrument representing payment from any insurance company for treatment renderd by this office. I agree that any payment in excess of the charges for treatment rendered will be credited to my account or forwarded to my address.

REJECTION IN WRITING: I hereby authorize the above facility/physician to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request of the provider, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is uable to provide said rejections in a timely maner, I acknowledge that I am entitled to minimum levels of coverage as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to the facility named above.

If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

I, _____ (print name), in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to **Next Level Chiropractic**, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the above rights, power and authority.

Signature of Patient/Guardian _____ **Date**_____

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic procedures, various forms of physical therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy tecniques. The risks of complications due to chiropractic treatments have been labeled as “rare” and include, but are not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dislocation and sprains. I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my symptoms and/or treatment options. If during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this facility/physician immediately. I understand that failure to do so may jeopardize my case.

I, _____ (print name), have read the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and intend this consent to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.