Browning Family Chiropractic & Wellness

Confidential Patient Information

Date_____

Name_____ SocialSecurity_____

Address_____ City _____

State_____ Zip Code_____ Email_____

Age_____ Date of Birth_____ Male Female Marital Status: M S W D

Home Phone _____Work Phone_____ Cell Phone_____

Children_____ Occupation_____ Employer_____

Address_____ Office Phone_____

Name of Spouse (or parent if minor) _____ Phone_____

Emergency Contact_____ Phone_____

Whom may we thank for referring you? _____

Purpose of this appointment/current problem _____

Other doctors seen for this condition _____

Is this condition due to injury arising out of employment or auto accident _____

Date symptoms appeared or accident occured_____Days lost from work___

Do you suffer from:

Dizziness _____	Neck Pain_____	Shoulder/Arm Pain_____	Nervousness_____
Back Pain_____	Arthritis_____	Hip/Leg Pain_____	Sinus Trouble_____
Heart Trouble_____	Headaches_____	Urinary Problems_____	Male/Female Trouble____
Diabetes_____	Numbness_____	Digestive Disorder_____	Cancer_____

Do you smoke ( )NO ( )YES _____packs/day Do you have a pacemaker ( )NO ( )YES

Who is your Primary Care Physician?_____

PCP Office name:_____ List medications_____

What vitamins are you taking_____

If female, are you taking birth control pills ( ) NO ( ) YES; Pregnant ( ) NO ( ) YES

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION: By signing this form, you are granting consent to Browning Family Chiropractic & Wellness to use and disclose your protected health information for the purposes of treatment, payment and health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

PATIENT SIGNATURE (or Guardian Signature Authorizing Care) Date

Insurance Company_____Insured_____SS#_____

1. What is your major symptom? _____

2. When was the first time you noticed this problem? _____

How did it occur? _____
Has it become worse recently? _____ If yes, when and how? _____
_____

3. How frequent is the condition? _____
How long does it last? _____

4. Have you ever had the same or a similar condition: ( ) No ( ) YES
If yes, when and describe: _____

5. Are there any conditions or symptoms you have that may be related to your major symptom? _____

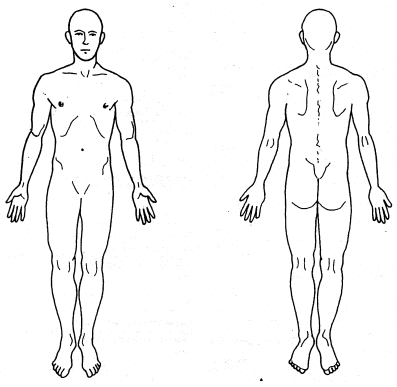
6. If pain is involved, is it – sharp, dull, throbbing, stabbing, aching, burning, tingling, shooting, (other)? _____

7. Is there anything you can do which seems to provide relief?_____

8. What makes the problem worse? _____

9. List accidents, illness, surgeries, or broken bones_____
_____

10. Please mark your symptom areas:



11. Rate the Severity of your condition:

0____1____2____3____4____5____6____7____8____9____10

(None) (Stops all activity)

ADDITIONAL FORM FOR CAR ACCIDENT PATIENTS ONLY

ACCIDENTAL INJURY FORM

NAME_____ DATE_____

Date of Accident_____ Time: ___am ___pm Location of Accident_____

AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

ON-THE-JOB INJURY

How did the injury occur?_____

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer:_____ Address:_____

OTHER

Describe the circumstances of the accident (Be Specific)_____

_____

_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache	( ) Sleeping Problems	( ) Lights Bother Eyes	( ) Diarrhea
( ) Neck Pain	( ) Head Too Heavy	( ) Loss of Memory	( ) Feet Cold
( ) Neck Stiff	( ) Pins & Needles in Arms	( ) Ears Ringing	( ) Hands Cold
( ) Dizziness	( ) Pins & Needles in Legs	( ) Face Flushed	( ) Stomach Upset
( ) Back Pain	( ) Numbness in Fingers	( ) Buzzing in Ears	( ) Constipation
( ) Nervousness	( ) Numbness in Toes	( ) Loss of Balance	( ) Cold Sweats
( ) Tension	( ) Shortness of Breath	( ) Fainting	( ) Fever
( ) Irritability	( ) Fatigue	( ) Loss of Smell	( ) Other
( ) Chest Pain	( ) Depression	( ) Loss of Taste	

Did you require post-accident hospitalization? ( ) Yes ( ) No
Have you lost any days of work? ( ) Yes ( ) No If Yes, _____ through _____
Have you had any treatment since accident?_____ If Yes, what type of treatment? _____

INSURANCE INFORMATION

Your Auto Insurance Company _____Address_____

Phone #_____ Policy #_____

Other Party's Name_____Address_____

Other Party's Auto Insurance Company_____ Address_____

Phone #_____ Policy #_____

Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No

If yes, name of adjustor_____Company_____

Phone #_____ Claim #_____

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, Attorney's name_____ Address_____

Phone #_____

Health Insurance Company_____ Insured_____

ID #_____

Signature_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPPA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPPA and has been advised that a full copy of this office's HIPPA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Dated this _____ day of _____, 20____

By _____
Patient's signature

If patient is a minor or under a guardianship order as defined by State Law:

By_____

Signature of Parent/Guardian (circle one)

****

HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

I authorize **Browning Family Chiropractic & Wellness** to use and disclose the protected health information described below to (name of individual seeking the information)

_____.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient's signature_____Date_____