Arise Family Chiropractic Health History Form

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

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

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Referral Source: _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ○ AM ○ PM ○ late PM

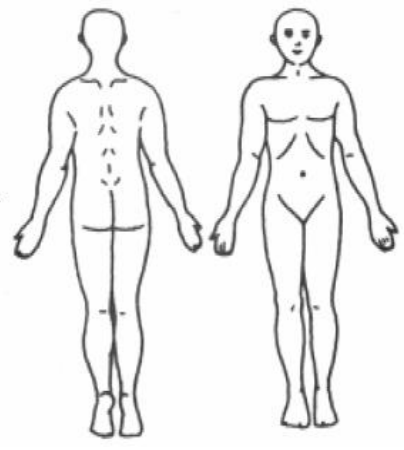
How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week

Condition(s) ever been treated by anyone in the past? ○ No ○ Yes **If yes,** when? _____ by whom? _____

Name of previous chiropractor: _____ ☐ **N/A**

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Is your problem the result of ANY type of accident? If **Yes** explain below. ○ Yes ○ No

_____

_____

PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the ***Past*** **C** for ***Currently*** have **N** for ***Never*** have had

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer

___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular

___ Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and conditions you feel may be contributing to your present problem:

Injuries/Type of Treatment/How long ago?_____

Surgeries/Type of Treatment/How long ago? _____

Childhood Diseases/Traumas? _____

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ○ No ○ Yes **If yes,** whom?

○ grandmother ○ grandfather ○ mother ○ father ○ sister(s) ○ brother(s) ○ son(s) ○ daughter(s)

2. Any other hereditary conditions the doctor should be aware of? ○ No ○ Yes:

_____

SOCIAL HISTORY

1. Smoking: ○ cigars ○ pipe ○ cigarettes How often?	○ Daily	○ Weekends	○ Occasionally	○ Never
2. Alcoholic Beverage: consumption occurs	○ Daily	○ Weekends	○ Occasionally	○ Never
3. Recreational Drug use:	○ Daily	○ Weekends	○ Occasionally	○ Never
4.Exercise: ○ Light ○ Moderate ○ Heavy	○ Daily	○ Weekends	○ Occasionally	○ Never

List Prescription drugs & Supplements you take. If none, please write N/A

_____

_____

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sit to Stand	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Climb Stairs	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walking	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Lift Children/Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Read/Concentrate	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Getting Dressed	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Shaving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sexual Activities	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Sitting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Standing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Yard work	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Pet Care	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Bathing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sweeping/Vacuuming	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Dishes	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Laundry	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Garbage	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Driving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: _____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Review**

REVIEW OF SYSTEMS

Please mark: P for in the Past C for Currently have N for Never

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS/Infertility	___ Lung Problems
___ Swollen/Painful Joints		___ Anxiety	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A, B,C)

INFORMED CONSENT: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such sprains/strains injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in on in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.
Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Arise Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____	_____	____/____/____
Patient Name (print)	**Patient Signature**	**Date**
_____	_____	____/____/____
Parent/Authorized Person Name (print)	**Parent/Authorized Person Signature**	**Date**
_____	_____	____/____/____
Witness Name (print)	**Witness Signature**	**Date**

If not signed by the patient, please indicate relationship: _____

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NOTICE OF PRIVACY PRACTICE AGREEMENT

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes: discussion with other healthcare providers in your care.
2. Inadvertent disclosure: open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes: to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes: to process a claim or aid in investigation.
5. Emergency: in the event of a medical emergency, we may notify a family member.
6. For public health and safety: in order to prevent or lessen a serious or eminent threat to the health or safety of a person.
7. To Government agencies or Law Enforcement: to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefit purposes.
9. Deceased persons: discussion with coroner and medical examiners in the event of a patient's death.
10. Telephone calls or email and appointment reminders: we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership: in the event this practice is sold, the new owners would have access to your Personal Health Information.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr Ilean Santos. If the doctor is unavailable, you may make an appointment with our receptionist to see a doctor within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201

I have received a copy of Arise Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserved the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that is maintains past and present. I am aware that a more comprehensive version of the "Notice" is available to me, and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient Name _____ Date _____

Patient Signature _____ DOB _____

Witness _____ Date _____

POLICIES AND FEES SCHEDULE

Consultation- includes practice member history (this service is complimentary)

Assessment (new or established practice member)- includes one or more of the following: thermography, heart rate variability, range of motion, posture assessment, motion and/or static palpation, leg check ($40-$75)

Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand or instrument. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place ($45-$60)

X-Rays- Specific X-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. Cost is subject to insurance rate, otherwise $50 per view (per cervical, thoracic, lumbar). Release of Authorization/Assignment of benefits I authorize and request payment of insurance benefits directly to Ilean Santos-Colon, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance.

I understand that I am financially responsible for charges not covered by insurance.

Signature_____Date_____

X-RAYS AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a records of your x-rays in our files. At your request, we will provide you with a copy of your X-ray in our files. **The fee for copying your X-rays on a disc is $15.00. This fee must be paid in advance.** Digital X-rays on CD will be available within 72 hours of prepayment on any regular practice hours day.

Please note: X-rays are utilized in this office to help locate and analyze **vertebral subluxations.** These X-rays are not used to investigate for medical pathology. The doctors of Arise Chiropractic do not diagnose of treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____	_____	____/____/____
Patient Name (print)	**Patient Signature**	**Date**
_____	**_____**	**____/____/____**
Parent/Authorized Person Name (print)	**Parent/Authorized Person Signature**	**Date**

By signing below, you are agreeing to the above terms and conditions

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

_____ (Initials) To the best of my knowledge, I believe I am not pregnant at the time X-rays are taken at Arise Family Chiropractic.

For Office Use Only

○ Lat Cervical Cm:_____	○Flex/Ext Cm:_____	○APOM Cm:_____	○Lower Cervical Cm:_____	○Lateral Thoracic Cm:_____	○A-P Thoracic Cm:_____
○ Lateral Lumbar Cm:_____	○A-P Lumbar Cm:_____	○ Other: Cm:_____			

HIPAA Personal Health Information Release

I, _____, hereby authorize Arise Family Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ○ Spouse Name: _____
- ○ Significant Other Name: _____
- ○ Parent/Legal Guardian Name: _____
- ○ Child(ren) Name(s): _____
- ○ Any Specified Person Name: _____
- ○ Information is not to be discussed with or released to anyone.

Restrictions:

- ○ No Restrictions
- ○ Only discuss my appointment time with the above-named individual(s).
- ○ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ○ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call ○ my home ○ my work ○ my cell phone
Phone Number: _____ - _____ - _____

If unable to reach me:

- ○ you may leave a detailed message
- ○ please leave a message asking me to return your call
- ○ _____

I understand I may terminate this consent at any time by giving written notice to Arise Family Chiropractic. Any changes to this form will require a new consent form to be completed, signed, and dated.

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.