SUMMIT CHIROPRACTIC HEALTH CENTER
28255 N. Tatum Blvd. #106
Cave Creek, AZ 85331
480.656.0263

HEALTH AND HISTORY ASSESSMENT

NAME:_____ TODAY'S DATE: _____/____/____ SEX: M / F

ADDRESS: _____CITY:_____STATE:_____ ZIP: _____

HOME PHONE: (____)_____BUSINESS PHONE: (____)_____

CELL PHONE: (____)_____EMAIL ADDRESS: _____@_____

HEIGHT: _____ WEIGHT: _____ RT/ LT HANDED BIRTHDATE: ___/____/____ MARITAL STATUS: S M W D

SOCIAL SECURITY #: _____ EMPLOYER:_____

OCCUPATION: _____ HOW DID YOU HEAR ABOUT OUR OFFICE?:_____

DO YOU HAVE INSURANCE: Yes/No

1. What is your main concern?: _____
2. How long have you had this condition?: _____
3. Have you lost work days: Yes/No How many?_____
4. Have you been experiencing any activity restrictions? (check all that apply)

   ___ Lifting ___Standing ___ Personal Grooming ___Sleeping ___Social Life ___Driving

   ___ Sitting ___ Bending ___ Kneeling/Climbing ___Walking ___Sexual Activity ___In/Out of Vehicle
5. Was the injury related to: Work Accident Yes/No Auto Accident Yes/No Other Yes/No Please explain:_____

   Describe what you feel caused this condition: _____

   _____
6. When did you last see a chiropractor? _____Dr: _____

   Why did you see this chiropractor? _____ Were you helped? Yes/No

   What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____

   Did you follow it? : Yes/No If no, why? _____Why are you changing Chiropractors? _____

A.
__ Fractured Bones
__ Auto Accidents
__ (a) - 0-1 years ago
__ (b) - 1.5 years ago
__ (c) - More than 5 years ago
__ Other Accidents/Falls
__ Knocked Unconscious
__ Back Curvature
__ Mental or Emotional Disorders
__ Arthritis
__ Diabetes
__ Swollen or Painful Joints
__ Convulsions/Epilepsy
__ Skin Problems
__ Bruise Easily
__ Cancer
__ Frequent Colds/Flu
__ Itching

B.
__ Nervous
__ Tension
__ Depressed
__ Irritable
__ Anemia
__ Excess Sweating – Tremors
__ Light Bothers Eyes
__ Sinus Problems
__ Allergy
__ Light Headed upon Rising
__ Under Stress
__ Crave Sweets or Salt
__ Eating Disorders

C.
__Trouble Sleeping
__Trouble Concentrating
__ Loss Of Memory
__ Learning Disabilities
__ Mistake Sides R/L
__ Stutter
__ Dyslexia
__ Mood Change
__ Lose Temper Easily

D.
__ Headache
__Neck Pain
__ Numbness, tingling, or pain in __ arms__Hands__fingers R/L
__ Jaw pain or click R/L
__ Heads seems to heavy
__ Hip pain R/L
__ Head & Shoulders feel tired
__ Difficulty in excessive (sitting, standing, walking, riding bending, and lifting)
__Shoulder Pain R/L
__ Foot trouble R/L
__ Dizziness
__ Ringing in Ears R/L
__ Hearing Loss R/L
__ Fainting
__ Blurred or double vision R/L
__ Upper back pain or arthritis R/L
__ Mid back pain or arthritis R/L
__ Lower back pain or arthritis R/L
__ Numbness, tingling or pain in buttocks, thighs, legs, feet,
__ Loss of Balance toes R/L
__ Pain with cough, sneeze or strain at stools

E.
__ Chest pain
__ Asthma
__ Lung problems
__ Difficult Breathing
__ Wheezing
__ Heart Problems
__ Stroke
__ High or low blood pressure
__Varicose Veins
__ Liver Trouble
__ Gall Bladder trouble

F.
__ Digestive problems
__ Excessive Gas
__ Belching/bloating after meals
__ Heartburn
__ Ulcers
__ Diarrhea/constipation
__ Colon trouble
__ Hemorrhoids
__ Prostate problems
__ Impotence

G.
__ Kidney trouble
__ Kidney stones
__ Frequent urination
__ Discharge
__ Menstrual problems/PMS
__ Menstrual problems
__Breast: lumps, soreness discharge
__ Pregnant (now)
__ Bed wetting
__ Ear infections
__ Hepatitis
__ Venereal Disease
__ AIDS/HIV
__ Other _____

7. Why did you come into our clinic and what are your expectations of us? _____
_____

8**. SOCIAL HISTORY**:

What are your favorite hobbies or activities to do now?: _____
Are your current problems affecting these activities or hobbies?: Yes/No
Do you take nutritional supplements? Yes/No If yes, describe:_____
Are you on any special diets? Yes/No If yes, describe: _____
Are you currently wearing: ___ Heel Lifts ___ Arch Supports
Do you smoke? Yes/No If yes, indicate number of packs a day: - Under 1__ 1__2 __ 3__ or more
Do you exercise? Yes/No If yes, describe: _____
Do you drink: __ Coffee __Tea __ Alcoholic beverages __ Soda If checked, how often _____
Do you sometimes feel that you do not have enough energy to get through the day? Yes/No

9. **FAMILY HISTORY** (please check those diseases that have affected you or your family) :

__ Heart disease	__Epilepsy	__Asthma	__Sinus problems
__Tuberculosis	__Anemia	__Retardation	__Other
__Cancer	__Diabetes	__HIV pos (AIDS)	
__Psychiatric	__Kidney disease	__High blood pressure	
__Overweight/Obesity	__Anorexia/Bulimia	__Circulatory Problem	

10. List all previous illnesses, injuries and hospitalizations/operations:

Area of body/Symptoms	Date	Describe (include any medication)
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. Are you currently being treated by another doctor? Yes/No
If yes, Whom? _____ Why?_____
12. Are you currently taking any over the counter or prescription medication? Yes/No
If yes, What?_____ Why? _____
Name of Medication: _____ Taking for? _____
Name of Medication: _____ Taking for? _____
Name of Medication: _____ Taking for? _____
Name of Medication: _____ Taking for? _____

I WILL BE PAYING BY:____CASH ____INSURANCE ____MEDICARE ____OTHER
If insurance, Name: _____Policy #_____

I certify this information to be true and correct. I assign my benefit payments to be paid directly to **Summit Chiropractic Health Center**; however, I understand that I am ultimately responsible for payment of service rendered. I also authorize the release of any information which is required for payment. Furthermore, I understand that **Summit Chiropractic Health Center** is not claiming to be a cure-all for my symptoms, and there are no guarantees.

_____ _____ _____
Patient or Guardian Signature Date Witness

Please feel free to discuss our fees. Fees are payable when services are received unless special arrangements are made in advance.

SUMMIT CHIROPRACTIC HEALTH CENTER

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as the relationship may effect the restoration and preservation of health.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation is a disturbance to the nervous system that occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Adjustment corrects and/or reduces subluxations, which is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Chiropractic care has been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:

_____

_____	_____
(Signature)	(Date)

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480.656.0263

To assist our patients in determining if they have a third party responsible for their health expenses, we need the following information.

INSURED: SOC SEC #:

DOB: PATIENT:

EMPLOYER: INSURANCE COMPANY:

ASSIGNMENT AUTHORIZATION, POWER OF ATTORNEY, AND AGREEMENT

In that this office is waiting for payment of its fees, I agree to provide the office with information and forms regarding any potential source of fee payment, to assist in any way I can, and

1. I hereby assign to this office my rights to receive payments from insurance companies. Payments should be made directly to:

   Summit Chiropractic Health Center

   28255 N. Tatum Blvd. #106

   Cave Creek, AZ 85331

   If my policy prohibits assignments, please make the check payable to me and mail to the above address.
2. I understand that if this office receives more than their fees, the office will pay any credit balances to me, the patient.
3. I authorize the office to release any information to any insurance company, adjustor, agent, or attorney that will assist in the payment of a claim.
4. I appoint this office as attorney-in-fact to correspond in my behalf with insurance companies and to cash any settlement draft or check. Counsel, insurance companies, and negligent parties be advised that no settlement can be effectuated without the agreement of this specific provision.
5. A photocopy of this form shall be valid as the original.

INSURED OR AUTHORIZED SIGNATURE DATE

NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMIT CHIROPRACTIC HEALTH CENTER is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practice with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

> ***"On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with Summit Chiropractic Health Center."***
>
> ***"It is our policy to provide a substitute healthcare provider, authorized by Summit Chiropractic Health Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situations."***

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

> ***"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payments to Summit Chiropractic Health Center for health care services rendered. If you pay for your health care services personally, we will as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."***

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner, and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below:

> ***"As a courtesy to our patients if you miss an appointment, it is our policy to call your home to reschedule your appointment time. If you are not at home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment with us.***
>
> ***It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation, or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the date and time, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Summit Chiropractic Health Center's sponsored fund-raising events."***

Office Practices

We may use your health information when showing gratitude for a referral by listing your name on our Referral Acknowledgement board, which hangs in the waiting room. Other patients may also view your personal health information on our daily sign in sheet.

Change of Ownership

In the event that Summit Chiropractic Health Center is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- **You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Summit Chiropractic Health Center is not required to agree to the restriction that you request.**
- **You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery upon you request.**
- **You have the right to inspect and copy your health information.**

- **You have the right to request that Summit Chiropractic Health Center amend your protected health information. Please be advised, however, that Summit Chiropractic Health Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.**

- **You have a right to receive an accounting of disclosures of your protected health information made by Summit Chiropractic Health Center.**

- **You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.**

Changes to this Notice of Privacy Practices

Summit Chiropractic Health Center reserves the right to amend this Notice of Private Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Summit Chiropractic Health Center is required by law to comply with this Notice.

Summit Chiropractic Health Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact the staff at Summit Chiropractic Health Center by calling this office at (480)656-0263.

Complaints

Complaints about your Privacy Rights, or how Summit Chiropractic Health Center has handled your health information should be directed to the staff at Summit Chiropractic Health Center by calling this office at (480)656-0263. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

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

This notice is effective as of April 14, 2003

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Summit Chiropractic Health Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

_____

Patients Name (Print)

_____ _____

Patients Signature **Date**

_____ _____

Authorized Facility Signature **Date**

CURRENT COMPLAINT HISTORY
(PATIENT)

Patient Name: _____ **Date:** _____

Please check all boxes that apply to your condition **and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.**

Please list your present complaint(s) and mark your level of pain today for each complaint – If you have more than one area of complaint, list them in order of most severe to least severe.

1. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** ____
   (***Please circle one.***) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**
2. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** ____
   (***Please circle one.***) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**
3. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** ____
   (***Please circle one.***) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**

Has anyone treated you for this episode? ❑Yes ❑No If yes, by whom? _____

How did your **symptoms begin?**

❑Immediately after a specific incident ❑After multiple Incidents ❑Gradually developed over time ❑Other _____

What makes your **symptoms better?**

❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

What makes your **symptoms worse?**

❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

Are your **symptoms?**

❑Decreasing ❑Increasing
❑Not Changing ❑Other _____

Description of pain or symptoms:

❑Sharp ❑Shooting
❑Dull ❑Burning
❑Ache ❑Numb
❑Weakness ❑Tingling
❑Throbbing ❑Other_____

Does your pain **move** or **radiate?**

❑Yes ❑No Where _____

Check the best and worse **times of the day** for your **pain**:

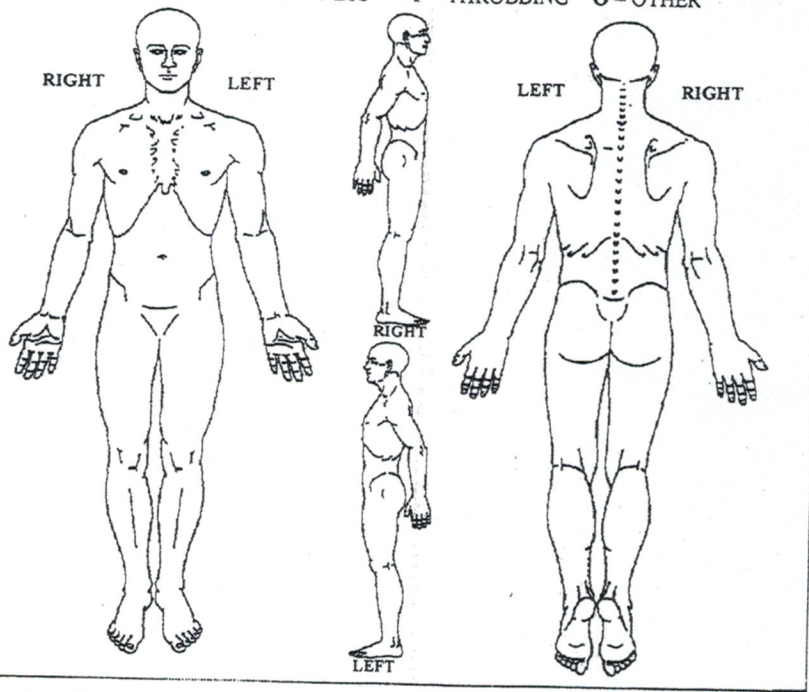
Worse	Best
❑First Awake	❑First Awake
❑Morning	❑Morning
❑Afternoon	❑Afternoon
❑Evening	❑Evening
❑Nighttime	❑Nighttime
❑Other	❑Other

Frequency of pain or symptoms:

❑Constant (76 – 100%)
❑Frequent (51 – 75%)
❑Occasional (26 – 50%)
❑Intermittent (25% or less)

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES
S = STABBING **X** = STIFFNESS **T** = THROBBING **O** = OTHER



How many days out of **an average week** are you in **pain?** (Please circle one.) 1 2 3 4 5 6 7

How much time during the **day** are you in **pain?**

❑less than 1 hour ❑1 to 6 hours ❑6 to 12 hours ❑12 to 18 hours ❑18 to 24 hours ❑24 hours

Patient's/Guardian's Signature: _____ **Date:** _____

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