ACTION Chiropractor LLC *Health and History Assessment*

ACCOUNT #: _____ HIPPA: _____ CTT: _____

NAME: _____ SEX: ☐ M/ ☐ F BIRTHDATE: _____/_____/_____

ADDRESS: _____ CITY: _____ STATE: _____ Zip: _____

PHONE #'s: HOME: (____) _____ WORK: (____) _____ CELL: (____) _____

HEIGHT: _____ WEIGHT: _____ MARITAL STATUS: _____ SOCIAL SECURITY # _____

EMAIL ADDRESS: _____ REFERRED TO OUR OFFICE BY: _____

EMPLOYER: _____ OCCUPATION: _____

DO YOU HAVE INSURANCE? ☐ YES/ ☐ NO IF YES, INSURANCE COMPANY NAME: _____

1. **Please Check Your Present Symptoms:**

☐ Headaches
☐ Neck Pain
☐ Neck Stiffness
☐ Memory Loss
☐ Shoulder Pain (☐ Right/ ☐ Left)
☐ Shoulder Stiffness (☐ Right/ ☐ Left)
☐ Difficulty Sleeping
☐ Leg Numbness
☐ Fatigue
☐ Overweight/Obesity
☐ Mid Back Pain
☐ Mid Back Stiffness
☐ Low Back Pain
☐ Low Back Stiffness
☐ Leg Pain (☐ Right/ ☐ Left)
☐ Leg Tingling (☐ Right/ ☐ Left)
☐ Arm Pain (☐ Right/ ☐ Left)
☐ Arm Tingling
☐ Arm Numbness
☐ Depression/Crying Spells
☐ Underweight/Anorexia
☐ Muscle Jerking
☐ Muscle Spasms
☐ Muscle Soreness
☐ Blurred Vision
☐ Buzzing/Ringing in Ears
☐ Difficulty Breathing
☐ Blood Pressure (☐ High/ ☐ Low)
☐ Joint Pain
☐ Tension
☐ Irritability
☐ Dizziness
☐ Fainting
☐ Other _____

2. **Of the above symptoms, which one is of MAIN concern to you? _____**

3. **When did you first notice the problem? _____**

4. **Was it caused by: ☐ Auto Accident ☐ On the job injury ☐ Other**

5. **Have you been treated for this condition? ☐ Yes ☐ No**

   If yes, when: _____ By Whom: _____

6. **Have you been treated by a chiropractor? ☐ Yes ☐ No**

   If yes, whom? _____ When:_____

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

Area of body/Symptoms	Date	Describe (please include medication)

8. **Are you currently being treated by another doctor?** ☐ **Yes** ☐ **No**

   If yes, Whom: _____ **Why:** _____

9. **Are you currently taking any over the counter OR prescription medication?:** ☐ **Yes** ☐ **No**

   If yes, What and For: _____

10. **Family History (Please check those diseases that have affected you or your family):**

☐ Heart Disease	☐ Epilepsy	☐ Asthma	☐ Sinus Problem	☐ Tuberculosis
☐ Anemia	☐ Retardation	☐ Cancer	☐ Diabetes	☐ Psychiatric
☐ Kidney Disease	☐ High Blood Pressure		☐ Overweight/Obesity	☐ Other _____
☐ Anorexia/Bulimia	☐ Circulatory Problem		☐ HIV Pos (AIDS)	

11. **SYSTEMIC REVIEW (Please check those symptoms or conditions that you have or have had):**

☐ Constipation	☐ Ear disorder	☐ Stroke	☐ Skin Problems
☐ Diarrhea	☐ Emphysema	☐ Cold Feet and Hands	☐ Worms
☐ Colitis	☐ Asthma	☐ Kidney Stones	☐ Liver Trouble
☐ Heartburn	☐ Allergies	☐ Frequent Sore Throat	☐ Nervous Stomach
☐ Gas	☐ Blood in Stool	☐ Irregular Heart Beat	☐ Chest Pain
☐ Vomiting	☐ Colon Trouble	☐ Spitting Up Blood	☐ Bed Wetting
☐ Bladder	☐ Sour/Acid Stomach	☐ Sex Problems	☐ High/Low Blood Pres.
☐ Blood in Urine	☐ Hiatal Hernia	☐ Arthritis	☐ Chronic Cough
☐ Kidney Infection	☐ Gall Bladder Problems	☐ Hemorrhoids	☐ Pain in Ribs
☐ Nausea	☐ Color Stool (☐ Black	☐ Brown ☐ White	☐ Tan)
☐ Other_____			

(WOMEN ONLY)

☐ Hot Flashes	☐ Irregular Period	☐ Excessive Flow	☐ Lumps in Breast
☐ PMS/Menopause	☐ Currently Pregnant	☐ Menstrual Cramps	☐ Other _____

(MEN ONLY)

☐ **Prostate Trouble** ☐ **Difficulty with Urination**

☐ **Other** _____

12. SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No If yes, indicate number of packs per day: ☐ Under 1 ☐ 1 ☐ 2 ☐ 3 & up

Do you exercise? ☐ Yes ☐ No If yes, describe: _____

Do you drink: ☐ Coffee ☐ Tea ☐ Alcoholic Beverages ☐ Soda

For any checked beverages, describe regularity: _____

Do you enjoy or crave sugars? ☐ Yes ☐ No Would you like to cut back sugar intake? ☐ Yes ☐ No

Do you sometimes feel that you do not have enough energy to get through the day? ☐ Yes ☐ No

Do you take nutritional supplements? ☐ Yes ☐ No If so, describe: _____

Are you on any special diets? ☐ Yes ☐ No If so, describe: _____

Evaluate the stress you get:

From your occupation: ☐ Severe/Constant ☐ Moderate ☐ Minimal ☐ None

From your family: ☐ Severe/Constant ☐ Moderate ☐ Minimal ☐ None

From finances: ☐Severe/Constant ☐ Moderate ☐ Minimal ☐ None

THANK YOU for completing this questionnaire. This information is necessary for the doctor in evaluating you condition. I authorize the release of any information required, and that my payment benefit be paid directly to this clinic. I understand that I am ultimately responsible for payment at time of service. Any outstanding balance is subject to additional fees.

I give my consent for examination and treatment by the doctors at this clinic. Further, I have received a copy of the office policies for HIPPA Compliance. Please sign below that this information is true and correct.

_____ _____

Patient of Guardian Signature **Date**

_____

Witness

ACTION CHIROPRACTIC LLC

CHIROPRACTIC & REHAB CENTER

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patients SS# _____ Date of Birth _____

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

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

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **ACTION Chiropractic LLC** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to **ACTION Chiropractic LLC** to use my name, address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives, newsletters or other health related information.

- I give permission to **ACTION Chiropractic LLC** to display my name on an internal referral board and/or patient sign-in sheet. In addition, I give permission to **ACTION Chiropractic LLC** to display my or my children's picture and/or chiropractic testimonial in the clinic and/or on Action Chiropractic's website.

- If **ACTION Chiropractic LLC** contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

- I give **ACTION Chiropractic LLC** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

- I give **ACTION Chiropractic LLC** permission to report my findings and review my x-rays with family and/or friends present in the room.

- By signing this form you are giving **ACTION Chiropractic LLC** permission to use and disclose your protected health information in accordance with the directives listed above.

You may restrict the individuals or organizations to which your healthcare information is released. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **ACTION Chiropractic LLC.** The written notice must contain the following information:

1. Your name, Social Security number and date of birth;
2. A clear statement of your intent to revoke this AUTHORIZATION;
3. The date of your request;
4. Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **ACTION Chiropractic LLC** for its own use/disclosure of PHI. *(Minimum necessary standards apply.)* Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **ACTION Chiropractic LLC** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

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

_____ _____
Print Patient name Date

_____ _____
Signature of Patient Authorized Provider Representative

_____ _____
Print Personal Representative Personal Representative Signature

_____
Description of Representative's Authority To Act for Patient

ACTION CHIROPRACTIC LLC

CHIROPRACTIC & REHAB CENTER

Consent for Chiropractic Treatment and Acknowledgment of Receipt of Information

Every type of healthcare is associated with some risk of a potential problem. Healthcare providers, including chiropractors, are required by law to tell you the nature of your condition, the general nature of the treatment, the risks involved, and the reasonable therapeutic alternatives. In keeping with the state & Federal law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. Please read this form carefully. Ask about anything you do not understand and we will be pleased to explain it. In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include but not limited to:

1) **Stroke:** Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the

neck vertebrae). This problem occurs so rarely that there is no conclusive data to quantify probability.

2) **Disc herniation:** Disc herniation creates pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem resulting in increased low back pain, radicular pain, and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.

3) **Soft tissue injury:** Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle of ligament fibers. The result is temporary increase in pain and necessary treatments for resolution but there are no long term affects for the patient.

4) **Rib fractures:** The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

Print Patient Name: _____

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

Witness:_____