# WELCOME!

Today's Date: ____/____/____

Your Name: _____[ ] Male [ ] Female

What do you prefer to be called? (Nickname)_____

Date of Birth: ___/___/____ Age: _____

Social Security Number: ____-____-____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Home Address: _____
City: _____State: _____Zip:_____
Home Phone: (___) _____Work Phone: (___) _____
Mobile Phone: (____) _____Email:_____

Emergency Contact: _____Phone: (___)_____

Employer: _____
Employer's Address: _____
Employer's City: _____State: _____Zip:_____
Occupation: _____

Who can we thank for referring us to you? _____
Can we contact him/her? [ ] Yes [ ] No

Health Insurance: _____
Insured's Name: _____
Insured's Social Security #:_____

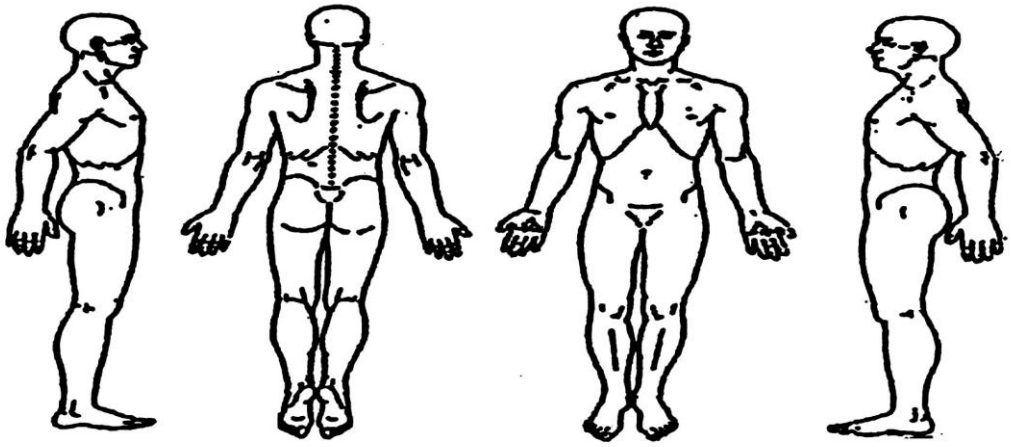
*Please have front desk copy your insurance card and photo ID.*

**THANK YOU☺**

Patient Name: _____ Date: _____

**1. Is today's problem caused by:** □ Auto Accident □ Workman's Compensation

**2. Indicate on the drawings below where you have pain/symptoms**



**3. How often do you experience your symptoms?**

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

**4. How would you describe the type of pain?**

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

**5. How are your symptoms changing with time?**

□ Getting Worse □ Staying the Same □ Getting Better

**6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?**

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

**7. How much has the problem interfered with your work?**

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

**8. How much has the problem interfered with your social activities?**

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

**9. Who else have you seen for your problem?**

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

**10. How long have you had this problem? _____**

**11. How do you think your problem began?**

_____

**12. Do you consider this problem to be severe?**

□ Yes □ Yes, at times □ No

**13. What aggravates your problem?**

_____

**14. What concerns you the most about your problem; what does it prevent you from doing?**

_____

**15. What is your: Height_____ Weight _____ Age _____**
**Occupation** _____

**16. How would you rate your overall Health?**

□ Excellent □ Very Good □ Good □ Fair □ Poor

**17. What type of exercise do you do?**
□ Stenuous □ Moderate □ Light □ None

**18. Indicate if you have any immediate family members with any of the following:**
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

**19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

| Past | Present | Past | Present | Past | Present |
|---|---|---|---|---|---|
| □ | □ Headaches | □ | □ High Blood Pressure | □ | □ Diabetes |
| □ | □ Neck Pain | □ | □ Heart Attack | □ | □ Excessive Thirst |
| □ | □ Upper Back Pain | □ | □ Chest Pains | □ | □ Frequent Urination |
| □ | □ Mid Back Pain | □ | □ Stroke | □ | □ Smoking/Tobacco Use |
| □ | □ Low Back Pain | □ | □ Angina | □ | □ Drug/Alcohol Dependance |
| □ | □ Shoulder Pain | □ | □ Kidney Stones | □ | □ Allergies |
| □ | □ Elbow/Upper Arm Pain | □ | □ Kidney Disorders | □ | □ Depression |
| □ | □ Wrist Pain | □ | □ Bladder Infection | □ | □ Systemic Lupus |
| □ | □ Hand Pain | □ | □ Painful Urination | □ | □ Epilepsy |
| □ | □ Hip Pain | □ | □ Loss of Bladder Control | □ | □ Dermatitis/Eczema/Rash |
| □ | □ Upper Leg Pain | □ | □ Prostate Problems | □ | □ HIV/AIDS |
| □ | □ Knee Pain | □ | □ Abnormal Weight Gain/Loss | | |
| □ | □ Ankle/Foot Pain | □ | □ Loss of Appetite | **For Females Only** | |
| □ | □ Jaw Pain | □ | □ Abdominal Pain | □ | □ Birth Control Pills |
| □ | □ Joint Pain/Stiffness | □ | □ Ulcer | □ | □ Hormonal Replacement |
| □ | □ Arthritis | □ | □ Hepatitis | □ | □ Pregnancy |
| □ | □ Rheumatoid Arthritis | □ | □ Liver/Gall Bladder Disorder | | |
| □ | □ Cancer | □ | □ General Fatigue | | |
| □ | □ Tumor | □ | □ Muscular Incoordination | | |
| □ | □ Asthma | □ | □ Visual Disturbances | | |
| □ | □ Chronic Sinusitis | □ | □ Dizziness | | |
| □ | □ Other:_____ | | | | |

**20. List all prescription medications you are currently taking:**
_____

**21. List all of the over-the-counter medications you are currently taking:**
_____

**22. List all surgical procedures you have had:**
_____

**23. What activities do you do at work?**

| | | | |
|---|---|---|---|
| □ **Sit:** | □ Most of the day | □ Half the day | □ A little of the day |
| □ **Stand:** | □ Most of the day | □ Half the day | □ A little of the day |
| □ **Computer work:** | □ Most of the day | □ Half the day | □ A little of the day |
| □ **On the phone:** | □ Most of the day | □ Half of the day | □ A little of the day |

**24. What activities do you do outside of work?**
_____

**25. Have you ever been hospitalized?** □ No □ Yes
if yes, why _____

**26. Have you had significant past trauma?** □ No □ Yes

**27. Anything else pertinent to your visit today?**_____

**Patient Signature**_____ **Date:**_____

# HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act [HIPAA] provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information [PHI]. These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules if HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I, _____Date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**