PATIENT INFORMATION

Welcome to Health in Harmony Chiropractic! Please allow our staff to photocopy your driver's license and all available insurance cards. We ask that you complete the attached documents; please print.

Full Name ______________________________________ Gender: **M F** Home Phone _________________

Address _________________________________ City _______________ State ________ Zip ____________

Age ________ Birth Date _____________ Marital Status: **S M W D Sep** No. Children ________

Your Employer ________________________ Your Occupation _________________ Years on Job ________

Address _________________________________ City ________________ State ________ Zip ___________

Work Phone _______________ Cell Phone _______________ E-mail Address ________________________

Insurance Company ____

Name of Spouse, Parent, or Guardian ______________________ Age ________ Birth Date _____________

Spouse's Employer ______________________ Spouse's Occupation ______________ Years on Job ________

Employer Address_____________________________ City _____________ State _______ Zip ___________

Work Phone_____________________

How did you find out about our office? ____

Describe the major complaints that bring you to our office: ____

____

____

Is your condition due to an accident? ☐ Yes ☐ No Date of your accident: ____________

Type of accident? ____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care pan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of an consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed *for a fee and as time permits.*

Payment Options (Please Indicate): ☐ Cash ☐ Check ☐ MasterCard ☐ Visa ☐ Discover

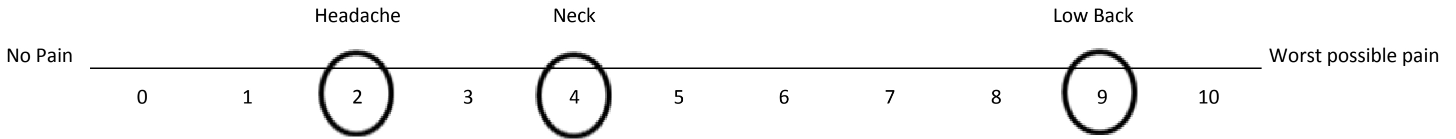
Patient Signature: ________________________________ Date: _______________

Spouse's or Guardian's Signature (if under 18): __________________________________ Date: ______________

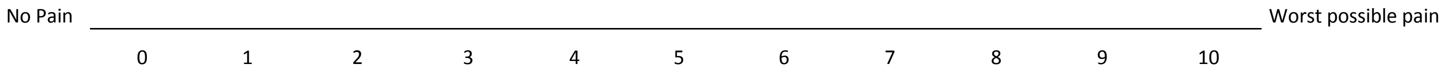
QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question being asked. Indicate your pain level right now, average pain, pain at its best, and at its worst. If you have more than one complaint, please answer each question for each individual complaint indicating the score for each complaint, as per the example below.

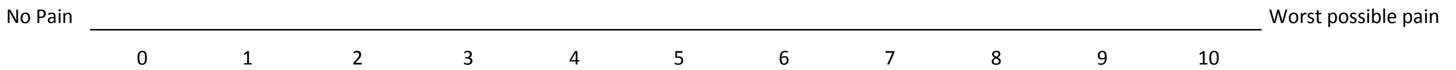
Example:



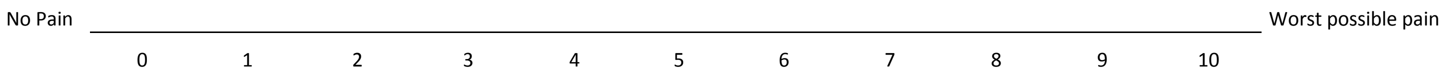
1. What is your pain RIGHT NOW?



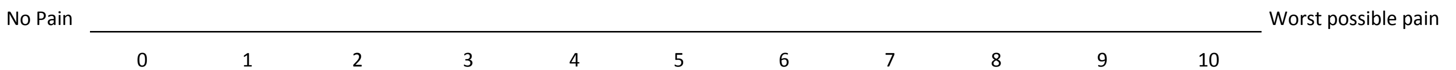
2. What is your typical or AVERAGE pain?



3. What Is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4. What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



Other comments:

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____

Patient Signature: ________________________________ Date: ________________

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health information will be used and I agree to these policies and procedures.

Patient Signature: _______________________________ Date: _______________

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient incoming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Health in Harmony Chiropractic, I authorized them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon request.

Patient Signature: ______________________________ Date: _______________

CASE HISTORY

Please answer the question below concerning your health history. Be sure to list all conditions or symptoms, both past and present.

Review of Systems

Do you have skin, hair or nail problems? ☐ Yes ☐ No ______________________________

Do you have ear, nose (sinus), or throat problems? ☐ Yes ☐ No ______________________________

Do you have eye problems? ☐ Yes ☐ No ______________________________

Do you have chest or lung (breathing) problems? ☐ Yes ☐ No ______________________________

Do you smoke? ☐ Yes ☐ No Amount per day? __________ How long? ______________

Do you have heart, blood, or lymph node problems? ☐ Yes ☐ No ______________________________

Do you have digestive problems? ☐ Yes ☐ No ______________________________

Do you have genital problems (e.g. prostate, testicular, vaginal)? ☐ Yes ☐ No ____________________

Do you have urinary (including kidney or bladder) problems? ☐ Yes ☐ No ____________________

Do you have any nervous system diseases and/or mental health problems? ☐ Yes ☐ No ______________

Do you have any gland and/or hormone problems? ☐ Yes ☐ No ______________________________

Do you have allergy or immunity problems? ☐ Yes ☐ No ______________________________

Do you have any muscle, tendon, or ligament problems? ☐ Yes ☐ No ______________________________

Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? ☐ Yes ☐ No

____

Females: Have you had menstrual problems? ☐ Yes ☐ No ______________________________

Have you ever taken birth control pills? ☐ Yes ☐ No For how long? ____________________

Is there any chance that you are currently pregnant? ☐ Yes ☐ No

Past History

List any diseases which you have had in the past, including childhood diseases: ____________________

____

Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.:

____

Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? ☐ Yes ☐ No

____

____

____

List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):

____Date:____________________

____Date:____________________

____Date:____________________

Patient Signature: ______________________________ Date: ______________

Have you ever been hospitalized for any reason other than surgery? ☐ Yes ☐ No ______________________

____

Medications

Please list all medications (prescription & non-prescription) you are currently taking or take on occasion:

____

____

____

Diet ☐ Balanced ☐ Fair ☐ Poor ☐ Excessive ☐ Restricted

Family History

Are there any disease or conditions that are common among your family members (i.e. inherited diseases or conditions)? ☐ Yes ☐ No ____

Social History

In what position do you usually sleep, and how well? ____

____

Do you exercise on a regular basis? ☐ Yes ☐ No How? ____

How do you spend your spare time (hobbies, etc.)? ____

Do you use:

☐ Caffeine ☐ Tobacco ☐ Nicotine ☐ Recreational Drugs ☐ Alcohol

Please describe your work.

Type: ☐ Professional ☐ Physical Labor ☐ Driver ☐ Clerical ☐ Factory ☐ Homemaker

Physical Demands: ☐ Heavy ☐ Moderate ☐ Mild ☐ Sedentary

Stress Level: ☐ High ☐ Medium ☐ Low

Additional Questions

Do you have problems with recurring headaches? ☐ Yes ☐ No ____________________________________

Are you losing weight without trying? ☐ Yes ☐ No

Does your pain wake you up at night? ☐ Yes ☐ No

Have you had a change in bowel or bladder habits? ☐ Yes ☐ No ________________________________

Have you had a sore that doesn't heal? ☐ Yes ☐ No ____

Have you recently had any unusual bleeding or discharge? ☐ Yes ☐ No ___________________________

Do you have a thickening/lump in the breast or elsewhere? ☐ Yes ☐ No __________________________

Have you had an obvious change in a wart or mole? ☐ Yes ☐ No ________________________________

Do you have a nagging cough or hoarseness? ☐ Yes ☐ No ____

In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.

____

____

Medical Doctor? ____________________ OB/GYN? ____________________ Dentist? ____________________

Patient Signature: _______________________________ Date: _______________