

# CHIRO RUS

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## Patient Profile

Full Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yy

Address: \_\_\_\_\_ Social Security\*: \_\_\_\_\_  
Street Address City / State / Zip Code \* insurance patients only

Phone: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_  
Name Phone

Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: Single Married Widowed Divorced Referred By: \_\_\_\_\_

Health insurance? No Yes If yes, Insurance Company: \_\_\_\_\_ Responsible party: Parent Other: \_\_\_\_\_

Health savings account account? No Yes Primary Care Doctor: \_\_\_\_\_

## Health History I

List of prescriptions, over-the-counter medications, vitamins or supplements you currently take:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List surgeries and approximate date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Implants, screws, plates, or other foreign objects?

Do you:  Exercise  Allergies \_\_\_\_\_  
 Smoke \_\_\_\_\_  
frequency

Have you ever been diagnosed with cancer:

No Yes: \_\_\_\_\_  
type

Date of most recent: (mm/yy)

CT Scan: \_\_\_\_\_ MRI: \_\_\_\_\_ Spinal Xray: \_\_\_\_\_

For Women Only:

Pregnant **N Y**  Last menstrual cycle \_\_\_\_\_  
 Given birth? **N Y** How many times? \_\_\_\_\_

## Health History II

Do you currently or have you previously had any of the following symptoms?

Current	Previous		Current	Previous	
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Digestive Issues	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Swelling in Joints	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps
<input type="checkbox"/>	<input type="checkbox"/>	Sudden Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Feet/Hands Cold			
<input type="checkbox"/>	<input type="checkbox"/>	Radiating Arm/Hand Symptoms			
<input type="checkbox"/>	<input type="checkbox"/>	Radiating Leg/Foot Symptoms			

## Reason for Visit

Reason for your visit: \_\_\_\_\_ Activities unable to perform: \_\_\_\_\_

When did the symptoms begin: \_\_\_\_\_

Previously received chiropractic care? N Y Reason \_\_\_\_\_ How long \_\_\_\_\_ Why was care stopped? \_\_\_\_\_

Which describes the frequency of your discomfort?  Constant  Intermittent  Frequent  Occasional

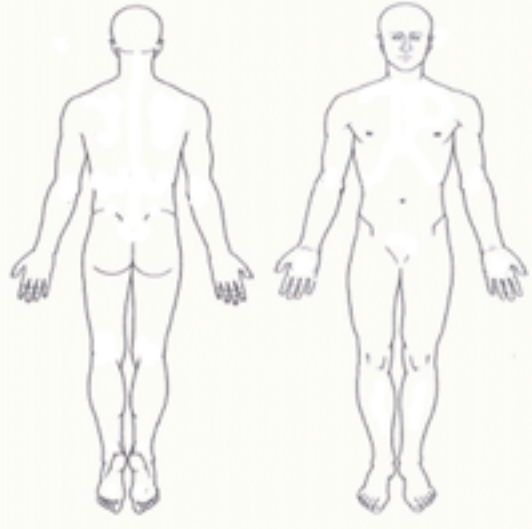
When is the pain worst?  Morning  Afternoon  Night  No change

What helps relieve the pain?  Medication  Heat  Ice  Nothing  Other \_\_\_\_\_

What causes discomfort during the day? Select all that apply

- Bending  Getting up  Reading  Lifting  Turning head  Sitting  Pulling  
 Pushing  Urination  Sneezing  Coughing  Driving  Lying Down  Standing  
 Sleeping  Walking  Working  Bowel Movement  Other \_\_\_\_\_

## Patient System Illustrator



### Instructions:

- Using diagram (left), circle affected body part(s).
- Below describe pain and rate the severity of pain in affected area.

1) Affected Body Part: \_\_\_\_\_ Side: L R Symptom(s):  Burning  Swelling  Numbness  
 Spasm  Pins & Needles  Dull Ache  
 Throbbing  Stiffness  Sharp Stabbing  
 Severity of pain:

2) Affected Body Part: \_\_\_\_\_ Side: L R Symptom(s):  Burning  Swelling  Numbness  
 Spasm  Pins & Needles  Dull Ache  
 Throbbing  Stiffness  Sharp Stabbing  
 Severity of pain:

3) Affected Body Part: \_\_\_\_\_ Side: L R Symptom(s):  Burning  Swelling  Numbness  
 Spasm  Pins & Needles  Dull Ache  
 Throbbing  Stiffness  Sharp Stabbing  
 Severity of pain:

4) Affected Body Part: \_\_\_\_\_ Side: L R Symptom(s):  Burning  Swelling  Numbness  
 Spasm  Pins & Needles  Dull Ache  
 Throbbing  Stiffness  Sharp Stabbing  
 Severity of pain:

## Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: <http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf>

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

**Initial** \_\_\_\_\_

**Consent to Professional Treatment** The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

**Initial** \_\_\_\_\_

**Consent to Perform and Interpret X-rays** The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

**Initial** \_\_\_\_\_

**Assignment of Benefits and Release of Records** The patient hereby assigns benefits to be paid directly to this provider by all of the third party payors. This assignment is irrevocable. Failure to fill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

**Initial** \_\_\_\_\_

**Financial Obligation and Appointment Policy** The patient accepts full financial responsibility for services rendered by this practice. An account which is past due and for which no payment arrangements have been made will be forwarded to a collection agency. Collection agency fees will be the responsibility of the patient.

**Initial** \_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name *if under 18*

\_\_\_\_\_  
Parent/Guardian Signature *if under 18*

\_\_\_\_\_  
Date