[ELITE]
CHIROPRACTIC + REHAB

Health History Questionnaire

Personal Information

Name:_____ Female ☐ Male ☐ Birth Date: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work:_____ Cell:_____

Email:_____

Employer:_____ Occupation:_____

Family Doctor name:_____

How did you hear about us? _____

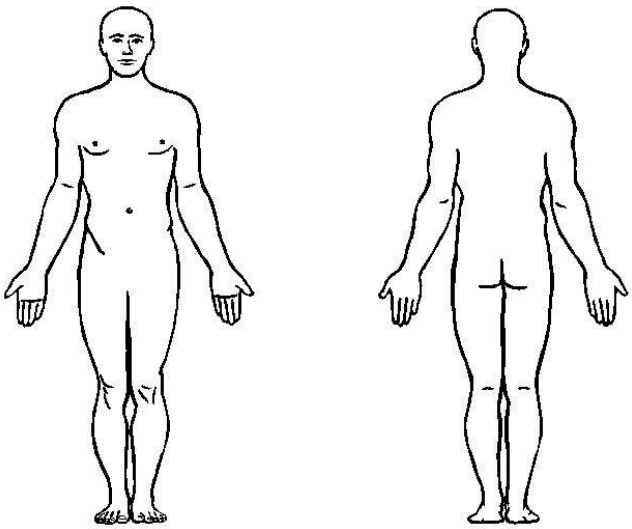
Using the symbols below, mark on the body diagram:

X = Pain

O = Numbness

Z = Tingling

/ = other _____



Using the scale below, please indicate the level of pain you are currently experiencing:

0	1	2	3	4	5	6	7	8	9	10
No Pain									Severe Pain	

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1. Reason for visit: _____

2. When did this begin? _____

3. Have you experienced this before? ☐Yes ☐No _____

4. Is this work related? ☐Yes ☐No Has your employer been notified? ☐Yes ☐No

5. Were you involved in a motor vehicle accident? ☐Yes ☐No Date of Injury: _____

6. Has the condition: ☐Improved ☐Worsened ☐Not changed since this began?

7. What interventions/treatments have you tried for this condition? _____

8. Have you had any X-rays, an MRI or other tests for this condition? If so, which tests and when were they taken? _____

9. Can you perform your daily <u>home</u> activities? ☐Yes ☐Yes, with help ☐Not at all

If limited, please explain: _____

10. Can you perform your daily <u>work</u> activities? ☐Yes ☐Yes, with help ☐Not at all

If limited, please explain: _____

11. Describe your stress level: ☐None ☐Mild ☐Moderate ☐High

12. Do you exercise? ☐Daily ☐2-3 days per week ☐Occasionally ☐Rarely/Not at all

If so, what type:_____

13. Please list any previous surgeries, illnesses, injuries, motor vehicle accidents:_____

_____

14. Have you had previous Chiropractic care? ☐Yes ☐No

15. List all current medications (prescription, vitamins, herbal supplements):_____

_____

16. What do you hope to achieve from this visit? Check all that apply:

☐Pain relief ☐Explanation of your condition ☐Exercises to prevent recurrence

17. Have you or a family member ever been diagnosed or told you have any of the following? Check all that apply:

High blood pressure ☐Yes ☐No Explain:_____

Diabetes ☐Yes ☐No Explain:_____

Tuberculosis ☐Yes ☐No Explain:_____

Cancer ☐Yes ☐No Explain:_____

Heart disease ☐Yes ☐No Explain:_____

Stroke ☐Yes ☐No Explain:_____

Osteoporosis ☐Yes ☐No Explain:_____

Are/were you a smoker? ☐Yes ☐No Explain:_____

18. Are you currently experiencing or have you ever experienced any of the following?

Visual disturbances (blurring, loss, double) ☐Yes ☐No

Hearing disturbances (loss, ringing, other noise) ☐Yes ☐No

Slurred speech or other speech problems ☐Yes ☐No

Difficulty swallowing ☐Yes ☐No

Dizziness ☐Yes ☐No

Loss of consciousness or momentary blackouts ☐Yes ☐No

Sudden collapse without loss of consciousness ☐Yes ☐No

Numbness, loss of sensation, weakness in the face, fingers, hands, arms, legs or any other parts of the body ☐Yes ☐No

If **yes,** please explain where: _____

Terms

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Elite Chiropractic and Rehab will furnish me with the necessary information to assist me in making a collection from my insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient signature_____ **Date**_____

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CONSENT TO TREAT

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
d) Radiographs - ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments

I intend this consent to apply to all of my present and future chiropractic care.

_____
Patient Signature (legal guardian)

_____
Patient Name (Please print)

Date_____

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HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be proved to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or ranging for other business activities. For example, we may disclose your protected health information to medical school students to see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the secretary of the department of health and human services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. **You may revoke the authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. In case of a breech you will be contacted by our office via USPS within 48 hours.

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YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) - under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information - this means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a healthcare item or service for which the healthcare provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications - you have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information - if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures - you have the right to receive an accounting of certain disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign below as an "Acknowledgment" form. Please note that by signing the acknowledgment for you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

_____ _____

Patient Signature Date