Confidential Health Information Questionnaire

Welcome to our clinic. This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need help please don't hesitate to ask!

Name: _____
Last First MI

Email address: Personal:_____ Work:_____

Mailing Address: _____

_____

Phone # (Home)_____ (Work)_____ (Cell) _____
Can we call you at work? ❑ Yes ❑ No Please check your contact preference: ❑ Home ❑ Work ❑ Cell

Date of Birth: _____/_____/_____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor
Race: ❑Caucasian ❑African American ❑Asian ❑Native American ❑Latin American ❑Other_____
Ethnicity: ❑Hispanic ❑Latino ❑Non-Hispanic/Non-Latino ❑Decline to Answer

Occupation:_____ Employer: _____

Spouse Occupation:_____ Spouse Employer: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Financial Information:

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Are you the policy holder? ❑Yes ❑No If no, who is the policy holder: ❑Spouse ❑Parent ❑Employer ❑Other

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's SS#: _____ Policy Holder's Employer: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

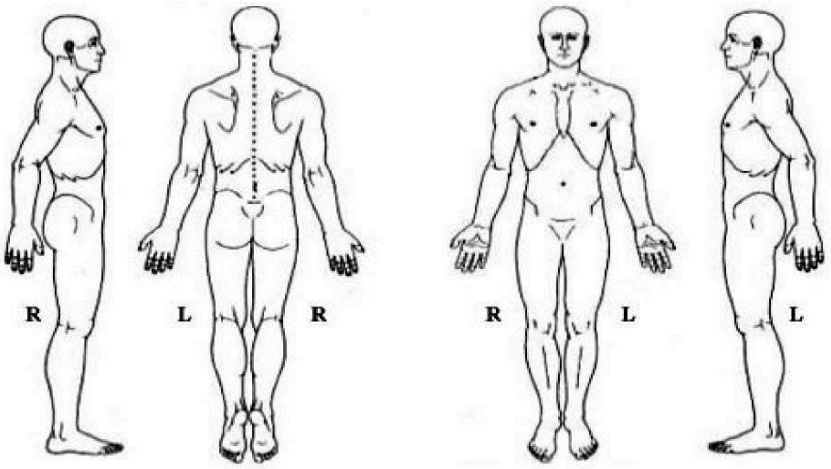
PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S) AND IDENTIFICATION

Our Philosophy:

You deserve to be healthy and our goal is for you to feel better than you have in years! When you were born, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, life is stressful. Emotional and physical stress, accidents, and other challenges can seriously impact your health. Today we will find out what is causing your health problems and determine a care plan that restores your health, so you can live the quality of life you deserve.

Current Health Condition:

Please shade in the area of your pain or symptoms in the image below.



What is your chief complaint / main health concerns for your visit today?

_____

Please briefly describe any other complaints you would like for us to also address:

_____

How long have you had the **main** health concern/problem? ❑ ____Days ❑____Weeks ❑____Months ❑ ____Years

Under what circumstances did the pain begin?

❑ Accident at work ❑ Accident at home ❑ At work but not incident ❑ Pain just began, no reason
❑ Following illness ❑ Following surgery ❑Motor Vehicle Accident ❑ Repetitive stress / overuse
❑ Following exercise/sports ❑Other_____

How would you describe your pain? ❑Aching ❑Stabbing ❑Shooting ❑Numb ❑Throbbing ❑Sharp ❑Burning

Your AVERAGE pain score is: (circle one)

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
None mild moderate severe very severe WORST

When your pain is at its WORST your pain score is: (circle one)

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
None mild moderate severe very severe WORST

When do your symptoms occur? ❑Constantly ❑ At Rest ❑With activity ❑ Other_____

Which statement best describes your pain?

❑Always Present, always the same intensity ❑ Usually Present, but have short periods without pain
❑ Always Present, Intensity varies ❑ Often Present, but I am pain free for most of the day

Do any of the following make your pain feel worse? (Check all that apply) ❑Bending ❑Sitting ❑Twisting
❑Standing ❑Walking ❑Lifting ❑Physical Activity ❑Coughing/Sneezing ❑Sexual Activity
❑ Lying Flat ❑ Can't find a comfortable position ❑ Other:_____

Does any of the following make your pain better? (Check all that apply) ❑Relaxation ❑Stretching ❑ Sitting
❑ Standing ❑Walking ❑ Lying down ❑ Medication ❑ Ice ❑ Heat ❑ Nothing makes it feel better

Does this pain radiate anywhere? ❑ Yes ❑No Where? _____

Please circle YES or NO for the following questions and answer appropriately:

Have you seen any other Doctors for the condition? What treatment was rendered? NO YES
_____

Have you tried any medications such as anti-inflammatory or Prescription Painkillers
for your complaint? If yes, what kind of medication? what side effects? NO YES
_____

Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
If yes: When? For how long? What kind?
_____

Have you previously had any recent imaging (MRI, CT, Xray) taken within the last 12 months? NO YES
If yes:
Type of Imaging:_____Date of Exam:_____
Facility Performed:_____Phone:_____

Medications you are currently taking (**Include over the counter, herbal, and natural remedies with dosage and frequency**):

_____ _____ _____

Please list any surgical history:

_____ _____ _____

Family & Social History

Is there a family history of?	Disc Disease	Heart Disease	Arthritis	Cancer	Diabetes
Father's Family	❑	❑	❑	❑	❑
Mother's Family	❑	❑	❑	❑	❑

Females only: Are you pregnant, planning a pregnancy or nursing a child? ❑ Yes ❑ No

Do you exercise?: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Do your work activities mostly involve?: ❑ Sitting ❑ Standing ❑ Computers ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following?:

Have you ever smoked? ❑ No ❑ Yes ❑ Cigar ❑ Pipe ❑ Cigarettes If yes, _____/day _____ # of years

Do you drink caffeinated beverages? ❑ Coffee ❑ Teas ❑ Sodas ❑ Energy Drinks regularly? _____/day

Do you use illegal drugs? ❑ No ❑ Yes If yes, what type? _____

Medical Signs or Symptoms

Constitutional Symptoms
- ☐ No symptoms
- ☐ Chills/Fever
- ☐ Loss of appetite
- ☐ Poor sleep/ insomnia
- ☐ Night sweats
- ☐ Recent weight loss
- ☐ Recent weight gain

Eyes, Ears, Nose and Throat
- ☐ No symptoms
- ☐ Earache R or L
- ☐ Decreased Hearing
- ☐ Nasal Congestion
- ☐ Sinus Trouble
- ☐ Difficulty swallowing

Cardiovascular
- ☐ No symptoms
- ☐ Chest Discomfort
- ☐ Chest Pain
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Leg Cramps at Rest
- ☐ Leg Cramps on Exertion
- ☐ Leg Swelling
- ☐ Pacemaker

Rheumatology:
- ☐ Osteoarthritis: Location:_____
- ☐ Rheumatoid arthritis
- ☐ Arthritis (unknown)
- ☐ Osteoporosis
- ☐ Gout
- ☐ Ankylosing spondylitis
- ☐ Other: _____

Genitourinary
- ☐ No symptoms
- ☐ Frequency
- ☐ Incontinence
- ☐ Urgency

Musculoskeletal
- ☐ No symptoms

Neck
- ☐ Pain
- ☐ Stiffness

Back
- ☐ Pain
- ☐ Stiffness
- ☐ Tenderness

Joints:(circle) hips, knees, feet, shoulder, elbow, hands
- ☐ Aching
- ☐ Arthritis
- ☐ Limitation of joint movement
- ☐ Redness
- ☐ Morning Stiffness
- ☐ Swelling
- ☐ Tenderness

Muscles
- ☐ Aches
- ☐ Weakness

Respiratory:
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Pulmonary Hypertension
- ☐ Tuberculosis

Neurological
- ☐ No symptoms
- ☐ Headaches
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Paralysis/Paresis
- ☐ Disorientation
- ☐ Vertigo/spinning
- ☐ Unsteadiness
- ☐ Dizziness

Psychiatric
- ☐ No symptoms
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Stressed
- ☐ Change in behavior

Endocrine
- ☐ No symptoms
- ☐ Diabetes
- ☐ Cold intolerance
- ☐ Excessive Sweating
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Hot flashes

Gastrointestinal
- ☐ No symptoms
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Peptic Ulcers
- ☐ Indigestion
- ☐ Nausea/ Vomiting
- ☐ GERD
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Gall Bladder
- ☐ Gluten Sensitivity

Pulmonary
- ☐ No symptoms
- ☐ Cough
- ☐ Asthma
- ☐ Pain with exertion

Please list any other signs or symptoms you are having that are not listed:

_____

_____

_____

_____

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT:

I certify that the above information is true and correct to the best of my knowledge. I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. When and if any charges that may be incurred for services are not paid in full by me or provided insurance, I agree to pay any and all collection and/or attorney fees with the original balance due. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

PATIENT SIGNATURE_____DATE _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as the relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

One disturbance to the nervous system is called a vertebral Subluxation. This occurs when one of more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by chiropractic adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral Subluxation. Our chiropractic method of correction is by specific adjustments or the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as rehabilitative procedures may be included.

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care professional.

All questions regarding the doctor's objective pertaining to may care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor/child:

I, _____ being the parent of legal guardian of _____

Have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____ _____

Print Name Signature Date

PATIENT ACKNOWLEDGMENT FORM - HIPPA

Patient's name: _____ Date of birth: _____

I understand that the patient's health information is private and confidential. I understand that Hope Health & Wellness work hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Hope Health & Wellness may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Hope Health & Wellness has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is available in the waiting room. I understand that I have the right to read the "Notice" before signing this Acknowledgment. I may also request a copy to take home.

Hope Health & Wellness may update this Acknowledgment and "Notice of Privacy Practices". If I ask, the clinic will provide me with the most current "Notice of Privacy Practices". Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; knowing in what ways my records are used by this practice; understanding how this office protects my privacy (for example rules regarding our sign-in sheet); and requesting communication be by specified methods of communications or alternative location.
Hope Health & Wellness has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Hope Health & Wellness by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Hope Health & Wellness's "Notice of Privacy Practices

_ _____

Patient or legally authorized individual signature Date Time

Relationship to patient if signed by anyone other than patient

_____