

Today's Date: \_\_\_\_\_

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

## UPDATED CONFIDENTIAL PATIENT HEALTH RECORD

Welcome back to **Crain Chiropractic & Wellness**. Please help us make sure our files are up to date by completing the following information the best you can.

### PERSONAL INFORMATION

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth (M/D/Y): \_\_\_\_\_ Sex: **M F** Marital Status: **S M W D**

Social Security Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Preferred method of communication for patient reminders: **Email Phone Text Mail**

Preferred Language: \_\_\_\_\_ Ethnicity: **Hispanic/Latino Not Hispanic/Latino I Decline to Answer**

Race: **American Indian/Alaska Native Asian Black/African American White (Caucasian)**

**Native Hawaiian/Pacific Islander I Decline to Answer**

Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Significant Other: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Name of Family Doctor: \_\_\_\_\_

I choose to decline receipt of my EHR clinical summary after every visit.

*(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

### IN CASE OF AN EMERGENCY, PLEASE CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

### GUARANTOR INFORMATION

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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**CURRENT HEALTH CONCERN**

I do not have a current concern but would like to be evaluated for wellness care. (Skip to Past Health History.)

Describe the primary reason for today's visit: \_\_\_\_\_

When did this start? \_\_\_\_\_

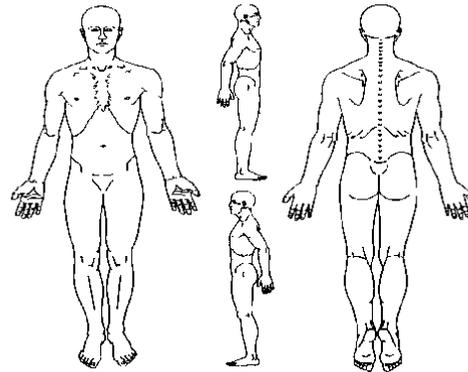
What do you feel caused this problem? \_\_\_\_\_

Pains are: **Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness**  
**Other:** \_\_\_\_\_

On a scale of 0-10 please circle the number that represents your current pain level:

- NO PAIN            **0**
- LOW PAIN         **1   2   3**
- MODERATE PAIN **4   5   6**
- INTENSE PAIN   **7   8   9**
- EMERGENCY     **10**

Please indicate where your pain is located:



Is your condition due to an accident? **Yes No**

Date of accident: \_\_\_\_\_ Type of accident? **Auto Work Home Other:** \_\_\_\_\_

Explain Accident: \_\_\_\_\_

What activities make your condition/pain worse? \_\_\_\_\_

What activities make your condition/pain better? \_\_\_\_\_

Is this condition interfering with **Work Sleep Routine Other:** \_\_\_\_\_

Is this condition getting progressively worse? **Yes No**

Have you seen anyone else for this? **Yes No** Who? \_\_\_\_\_

Have you experienced this in the past? **Yes No** How many times? \_\_\_\_\_

**PAST HEALTH HISTORY**

Any additional illnesses, surgeries, or injuries since your most recent evaluation with us? **Yes No**

Explain: \_\_\_\_\_

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### REVIEW OF SYSTEMS

Please identify any changes in the following areas since your most recent evaluation with us.

	Worse	Same	Improved
<b>General</b> - fainting, low libido, poor appetite, fatigue, sudden weight change, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Musculoskeletal</b> – osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b> – anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular</b> – high blood pressure, low blood pressure, high cholesterol, angina, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory</b> – asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal</b> – ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eyes, Ears, Nose, Throat</b> - blurred vision, ringing in ears, hearing loss, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine/Immunological</b> – thyroid issues, hypoglycemia, frequent infection, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Genitourinary</b> – kidney stones, infertility, bed wetting, prostate issues, PMS symptoms, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### HEALTH HABITS & SOCIAL HISTORY

Are you currently taking any medications? *(Include regularly used over the counter medications)*

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Do you supplement your diet? **Yes No**

<input type="checkbox"/> Multivitamin	<input type="checkbox"/> Essential Fatty Acids (Fish Oil)
<input type="checkbox"/> Probiotic	<input type="checkbox"/> Vitamin D
<input type="checkbox"/>	<input type="checkbox"/>

How often are you currently exercising? **Never Daily 1X/week 2X/week 3X/week 4 or moreX/week**

What type of exercise program is it? \_\_\_\_\_

Do you drink alcohol? **Yes No** If yes, how much? \_\_\_\_\_

Do you drink coffee, tea or soda? **Yes No** If yes, how much? \_\_\_\_\_

Smoking Status (Circle one): **Every Day Smoker Occasional Smoker Former Smoker Never Smoked**

Approximately how many ounces of water do you drink per day? \_\_\_\_\_

What are the major stresses in your life currently? \_\_\_\_\_

How would you rate the level of stress? **High Moderate Low**

What is your preferred sleeping position: **Side Stomach Back**

What are your hobbies? How do you spend your free time? \_\_\_\_\_

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**INFORMED CONSENT & AUTHORIZATION FOR CARE**

The practice of chiropractic includes many standard examination and testing procedures, as well as, therapeutic procedures. These include physical examination, orthopedic and neurological testing, specialized chiropractic examinations, radiological (x-ray) examination, and laboratory testing (when clinically indicated). Procedures performed by chiropractors include various physical therapy and rehabilitation procedures and the procedure unique to the chiropractic profession – the chiropractic adjustment. Chiropractic adjustments are delivered to patients by chiropractors to correct spinal or extremity (ankle, knee, wrists, etc.) joint dysfunction. Within the chiropractic profession these dysfunctions are called subluxations. A subluxation is a condition that exists when one or more bones of the spine (called vertebrae) or extremities are misaligned sufficiently to cause a lack of motion in these joints, as well as, interference and/or irritation of the nervous system. The primary goal in chiropractic health care is the removal of subluxations and the restoration of normal joint motion and nervous system function.

It is not enough that you understand the benefits of chiropractic care in restoring normal joint motion and nervous system health, you must also be aware of the existence of the inherent risks and limitations of chiropractic care. Every type of treatment (medical, chiropractic, or otherwise) carries some form of potential risk associated with it. Risks associated with some forms of chiropractic care include muscular sprain/strain, neurological deficit, osseous fracture, and vertebral artery dissection (stroke). While the incidence of injury from chiropractic care is extremely low, and only seldom are the risks great enough to contraindicate care, these facts should be considered in making the decision to receive chiropractic care.

*I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the potential risks of chiropractic care; including the risk that care I receive in this office may not accomplish the intended clinical objective. I have been advised of reasonable alternative treatments including known risks, consequences, and probable effectiveness of each, and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been provided to me concerning the results of the care I will receive.*

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT TO TREATMENT OF MINOR CHILD (if applicable)**

*As parent and/or legal guardian, I have the authority to authorize, and do hereby grant permission to Dr. Crain at Crain Chiropractic & Wellness to administer chiropractic care as she deems necessary to my son/daughter/ward.*

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your Personal Health Information (PHI) will never be given to any entity besides what is required for your treatment, payment, and health care operations. Disclosure of your PHI without authorization is strictly limited to defined situations that include other healthcare providers for the benefit of your health and well-being, with applicable insurance companies to justify the necessity of services rendered or to obtain payment for such services, with applicable attorneys to aid in case settlement or litigation, and with law enforcement officials to aid in legal or criminal investigations. You have the right to review your records or request copies of them at any time. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. You may request restrictions on your disclosures.

*I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.*

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCIAL POLICY & ASSIGNMENT OF BENEFITS**

*Chiropractic care in this office deals with vertebral subluxation, and will therefore be billed under the S8990 adjustment code. While we will provide an itemized receipt upon your request, we anticipate that care will not be reimbursed by a third-party carrier. (This does not apply to PI or Medicare.) I understand that I am financially responsible for ALL costs incurred in this office, whether my insurance pays or not. HSA and FLEX spending accounts may be utilized. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.*

*In the event of a PI claim, I authorize the direct payment to Crain Chiropractic & Wellness of any sum I now or hereafter owed by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or Crain Chiropractic & Wellness based in whole or in part upon the charges made for services received. I hereby appoint Crain Chiropractic & Wellness authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered.*

*Advanced Beneficiary Notice of NON-Coverage (ABN). Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our staff. Signing below means that you have received and understand this notice.*

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_