Doctor's Confidential Patient Health History

Patient Data **Date**

How did you hear about our office? _____

Tell Us About You: (Check one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. □ Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address: _____

City _____ **State** _____ **Zip Code** _____

Cell Phone (_____) _____-_____ **Home Phone (_____)** _____-_____

Email _____

Date of Birth _____/_____/_____ **Sex:** □ Male □ Female

Marital Status: □ Single □ Married □ Other **# of Children and Ages**: _____

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Ethnicity: Not Hispanic or Latino/ Hispanic or Latino/ Other/ Decline Answer **Language:** _____

Race: White (Caucasian)/ Asian/ Black or African American/ American Indian or Alaskan Native/ Hawaiian or Pacific Islander/ Other/ Decline Answer

Smoking Status: Everyday/ Some days/ Former/ Never

Payment/Insurance Information:

Who is responsible for your bill? □ Self □ Health Insurance □ Spouse □ Worker's Comp
□ Auto Insur. □ Medicare □ Medicaid □ Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Cell Phone (_____) _____-_____

Medical Conditions: (Check all that apply to you)

□ Arthritis □ Cancer □ Diabetes □ Heart Disease
□ Hypertension □ Psychiatric Illness □ Skin Disorder □ Stroke
□ Other _____

Surgeries: List Type, Date and Reason: None

_____

_____

Allergies (List): _____

Social History: (Check all that apply to you)

Caffeine use:	□ occasional	□ often	□ never
Drink Alcohol:	□ occasional	□ often	□ never
Exercise:	□ occasional	□ often	□ never
Chew Tobacco:	□ occasional	□ often	□ never
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never

Family History: (Check all that apply)

Arthritis:	□ Parent	□ Sibling
Cancer:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling
Heart Disease	□ Parent	□ Sibling
Hypertension	□ Parent	□ Sibling
Stroke	□ Parent	□ Sibling
Thyroid	□ Parent	□ Sibling

Other _____

Please list all current medications being taken: _____

_____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

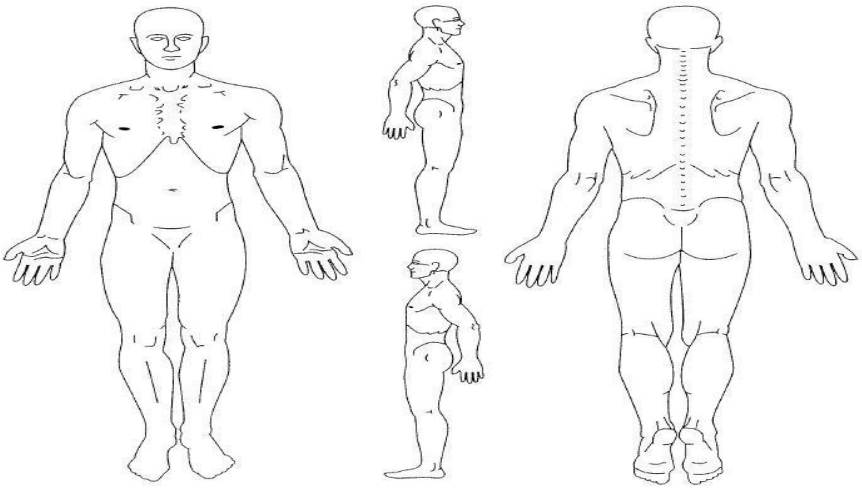
Cardiovascular			**Respiratory**			**Allergic/Immunologic**		
	Present	NO		Present	NO		Present	NO
Poor Circulation			Asthma			Hives		
Hypertension			Tuberculosis			Immune Disorder		
Aortic Aneurism			Short Breath			HIV/AIDS		
Heart Disease			Emphysema			Allergy Shots		
Heart Attack			Cold/Flu			Cortisone Use		
Chest Pain			Cough					
High Cholesterol			Wheezing					
Pace Maker						**Ear, Nose and Throat**		
Jaw Pain			**Eyes**				Present	NO
Irregular Heartbeat				Present	NO	Difficulty Swallowing		
Swelling of legs			Glaucoma			Dizziness		
			Double Vision			Hearing Loss		
Genitourinary			Blurred Vision			Sore Throat		
	Present	NO				Nosebleeds		
Kidney Disease			**Psychiatric**			Bleeding Gums		
Burning Urination				Present	NO	Sinus Infections		
Frequent Urination			Depression					
Blood in Urine			Anxiety			**Gastrointestinal**		
Kidney Stones			Stress				Present	NO
Lower Side Pain						Gall Bladder Problems		
			Endocrine			Bowel Problems		
Neurologic				Present	NO	Constipation		
	Present	NO	Thyroid			Liver Problems		
Stroke			Diabetes			Ulcers		
Seizures			Hair Loss			Diarrhea		
Head Injury			Menopausal			Nausea/Vomiting		
Brain Aneurysm			Menstrual			Bloody Stools		
Numbness						Poor Appetite		
Severe Headaches			**Hematologic**					
Pinched Nerves				Present	NO	**Musculoskeletal**		
Parkinson's			Hepatitis				Present	NO
Carpal Tunnel			Blood Clots			Gout		
Vertigo			Cancer			Arthritis		
			Bruising			Joint Stiffness		
Constitutional			Bleeding			Muscle Weakness		
	Present	NO	Fever, Chills			Osteoporosis		
			Sweating			Broken Bones		
Weight Loss/Gain						Joints Replaced		
Low Energy Level								
Difficulty Sleeping								

Please Answer All Questions

Are you pregnant? Yes_____ No _____N/A_____

Major Complaint(s): _____

Draw Areas of Complaints:



When did your symptoms begin? _____

Are your symptoms a result of a Motor Vehicle Accident? Yes / No

How did your symptoms begin? _____

How often is the pain occurring: Constantly Frequently Intermittently Occasionally

Intensity: None (0) Mild(1-2) Mild-Moderate(2-4) Moderate(4-6) Mod-Severe(6-8) Severe(8-10)

Is the Complaint: Sharp/ Stabbing/ burning/ Achy/ Dull/ Stiff & Sore/ pins + Needles/ Numb/ Other:

How are your symptoms changing?
□ Getting better □ Not changing □ Getting worse

I have read the above information and certify it to be true and correct to the best of my knowledge and herby authorize this office to provide me with Chiropractic and Acupuncture care, diagnostic testing, therapeutic services, in accordance with this state's statues.

Patient or Guardian Signature _____ Date: _____

Doctor Signature: _____ Date: _____

Combined Chiropractic & Acupuncture
115 Commons Drive Suite D
Mooresville, NC 28117

HIPAA

Before this office begins any health care operations, we require you to read and sign this form stating that you understand the below item. It you refuse to sign this form the doctor reserves the right to refuse care.

Authorizations: By signing below, you authorize this office/provider to complete a consultation and examination on the above.

Acknowledgement of Assignment of Benefits: By signing below you have acknowledged that you are fully responsible for all services rendered. By singing below you further acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of these fees charged to your account. By signing below, your herby assign benefits to paid directly to this office/provider by your third-party payer, e.g. Insurance company, attorneys, etc. By signing below, you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 Health Insurance Claim Form: by signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 ad Box 13 will state "signature on file". Box 12 reads as follows: "Patient's or Authorized Person's Signature I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 reads as follows: "Insured's or Authorized Person's Signature I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

Acknowledgement of Notice of Privacy Practices: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, email, and also regular mail. Messages may be left on an answering machine or voicemail, or with the person answering your phone-home-work-mobile devices. Also, in accordance with the health Insurance Probability and Accountability Act of 1966 (HIPAA), this office is obligated to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your right as a patient. By signing below, you have acknowledged that you have been offered a copy of this document.

Acknowledgement of Treatment Plan: By signing below I acknowledge that, if accepted for care, I may be presented with a Chiropractic treatment plan resulting in one or more of the following services: Chiropractic adjustments, examinations, acupuncture, and supportive therapies and procedures.

Acknowledgement: By signing below, you have acknowledged that you understand and agree with the policies and procedures outlines in this TERMS OF ACCEPTANCE form. By signing below, you acknowledge and certify that all the information provided to the office/provider in the INTAKE forms are a true and accurate to the best of your knowledge.

Signature of Patient: _____ Date: _____
Printed Patient Name: _____
Signature of Parent or Guardian: _____ Date: _____

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115 Commons Drive Suite D
Mooresville, NC 28117

By reading below I have been made aware:

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or extremities (arms, legs, etc.), often resulting in an audible "pop" or "clicking" sound.

2. As an addition to the Chiropractic Adjustment "Supportive therapies and/or procedures" may be applied by the Chiropractor or by staff under the Chiropractor's direction and supervision incorporating the use of sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, cold, acupuncture.

3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravating of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment.

4. That the Chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:
1. I have been afforded ample opportunity for questions and answers.

Therefore, by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office Chiropractor involved in my case.

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office Chiropractor involved in my case.

Patient Signature: _____ Date: _____

Printed Patient Name: _____

Witness Signature: _____ Date: _____