Current Health Condition

File Number (   )

Patient Information:

Today's Date ____________________
Name ____________________
I prefer to be called ____________________
Address ____________________
____
____
Sex ☐ **Male** ☐ **Female**
Occupation ____________________
Employer ____________________

Cell ____________________
Home Phone ____________________
Work Phone ____________________
Email ____________________
Social Security # ____________________
Date of Birth ____________________
Height ____' ____" Weight ______ lbs
Marital Status ____________________
No of Children ____________________

Address ____________________
If minor, name of parent or guardian ____________________
Who should we contact in case of an emergency? ____________________
Relation ____________________ Phone ____________________
Address ____________________
Phone ____________________
Primary Care Physician ____________________ Phone ____________________
How did you hear about our office? ____________________
Have you ever been to a chiropractor before? ☐ **YES** ☐ **NO** If so, whom? ____________________

Health Insurance Information:

Insurance Company ____________________
Policy Holder's Name ____________________
Address ____________________

Policy number ____________________
Social Security# ____________________
Phone ____________________

Primary Reason for Visit: ____________________

Other Doctor's seen for this condition: ____________________

When did this condition begin? ____________________

What makes this condition worse? ____________________

What relieves this condition? ____________________

Are there others in your family with this same condition? ☐ Yes ☐ No

Have you ever been under Chiropractic Care? ☐ Yes ☐ No If Yes? Dr's Name: ____________________

If, Yes how would you rate your experience? **Excellent Good Bad** Date of last visit? ____________________

Have you been treated for any other health condition in the last year? ☐ Yes ☐ No

If Yes, Please explain: ____________________

Is there anything we have not asked that you should tell us? If So, what? ____________________

____

Please indicate your daily job duties and any activities that you are occasionally asked to perform:

☐ **STANDING**	☐**OPERATING EQUIPMENT**	☐**DRIVING**	☐**SITTING**
☐ **TWISTING**	☐**WORK W/ARMS ABOVE HEAD**	☐**WALKING**	☐**CRAWLING**
☐ **TYPING**	☐**LIFTING**	☐**BENDING**	☐**STOOPING**

What positions can you work in with minimum physical effort, and for how long? ____________

Do you work with others who can help you with any heavy lifting? ☐ **YES** ☐ **NO**

While in recovery, are there any light duty tasks you could request? ☐ **YES** ☐ **NO**

Health History

Have you ever had any of the following diseases or conditions?

☐**HEART ATTACK or STROKE**	☐**HEART SURGERY or PACEMAKER**	☐**HEART MURMUR**
☐**CONGENITAL HEART DEFECT**	☐**MITRAL VALVE COLLAPSE**	☐**ARTIFICIAL VALVES**
☐**ALCOHOL/DRUG ABUSE**	☐**VENEREAL DISEASE**	☐**HEPATITIS**
☐**HIV/AIDS**	☐**SHINGLES**	☐**CANCER**
☐**FREQUENT NECK PAIN**	☐**EMPHYSEMA**	☐**ANEMIA**
☐**HIGH/LOW BLOOD PRESSURE**	☐**PSYCHIATRIC PROBLEMS**	☐**RHEUMATIC FEVER**
☐**SEVERE/FREQ. HEADACHES**	☐**KIDNEY PROBLEMS**	☐**ULCERS/COLONITIS**
☐**FAINTING/SEIZURE/EPILEPSY**	☐**SINUS PROBLEMS**	☐**ASTHMA**
☐**DIABETES**	☐**DIFFICULTY BREATHING**	☐**TUBERCULOSIS**
☐**LOWER BACK PROBLEMS**	☐**ARTIFICIAL BONES/JOINTS**	☐**ARTHRITIS**

Please list **any other** medical conditions that you have or have ever had. ____________

____

Please list any allergies. ____________

____

Please list previous surgeries and dates. ____________

____

Please list any past motor vehicle accidents or traumas and ____________

____

Is there anything else about your health history or family health history that you feel is important to share? ____________

____

Do you exercise? ☐ **YES** ☐ **NO**

Are you on a special diet? ☐ **YES** ☐ **NO** Since: ___/___/___

Do you smoke? ☐ **YES** ☐ **NO** How much? ________ How long? ________

Are you wearing: ☐ **ORTHOTICS** ☐ **HEEL LIFTS** ☐ **ARCH SUPPORTS**

For women: Are you taking birth control? ☐ **YES** ☐ **NO**

Are you pregnant? ☐ **YES** ☐ **NO** How long? ______ Nursing? ☐ **YES** ☐ **NO**

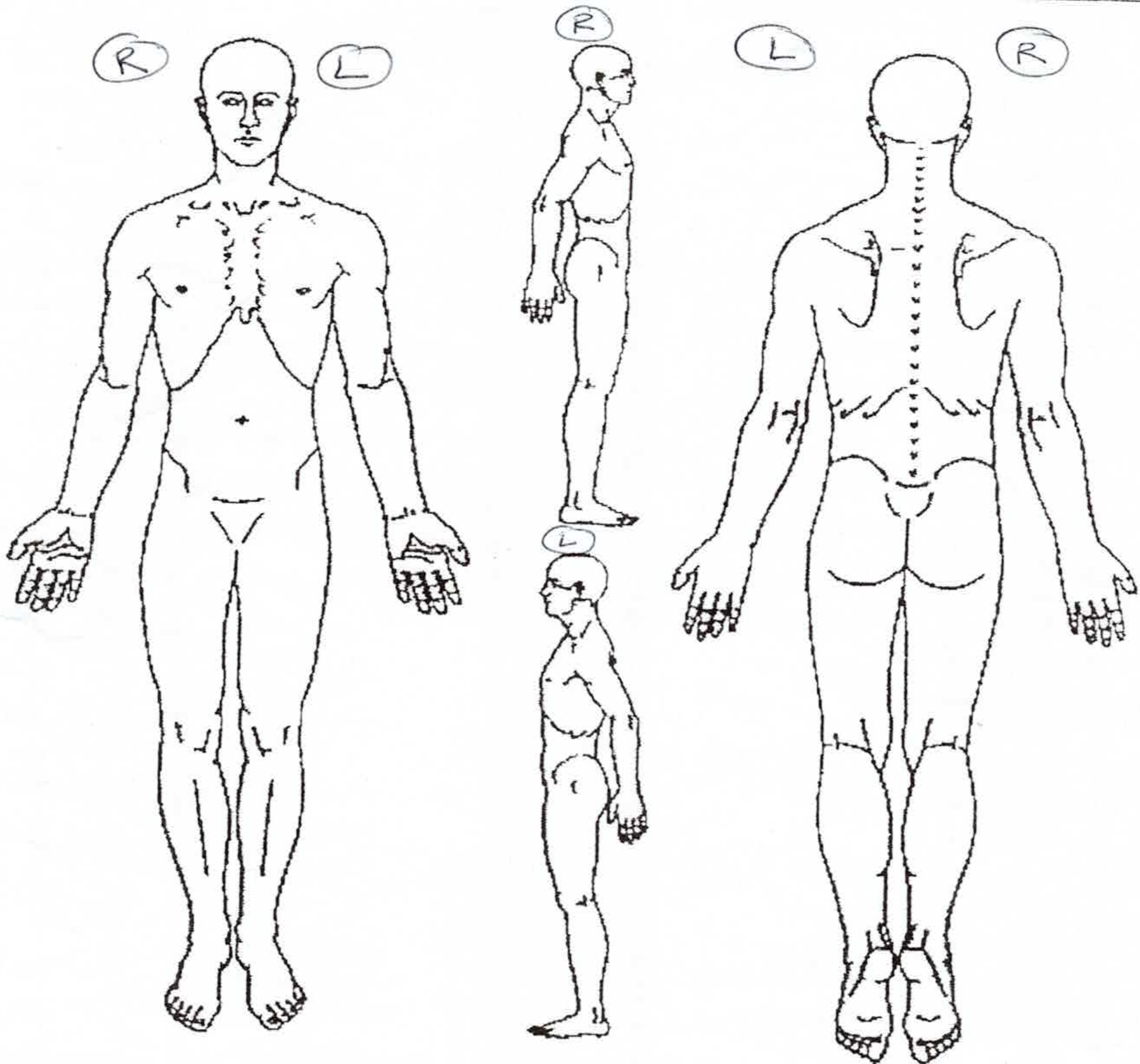
Patient/Legal Guardian Signature____________________ **Date** ____________

PAIN DIAGRAM

NAME ______________________________ DATE ____________

How long have you had pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE
P = PINS & NEEDLES
B = BURNING
S = STABBING
N = NUMBNESS
O = OTHER

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name ____________________ Date ____________

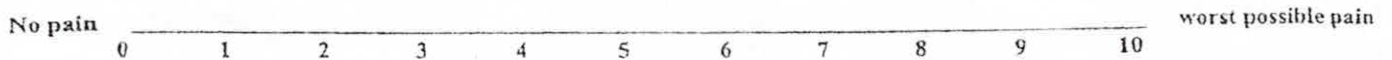
Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

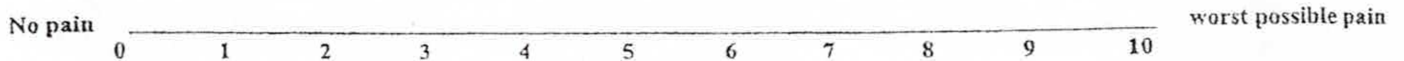
Example:

1 – What is your pain RIGHT NOW?

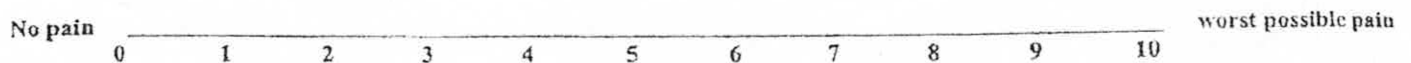


2 – What is your TYPICAL or AVERAGE pain?

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

____

____

____
Examiner

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HIPPA 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 describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment of health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that my identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations 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, 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.

Payment: Your protected health information will be issued, 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 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 and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients are 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.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigative or determine our compliance with the requirement of 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 this 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.

____________________________ ____________________
Patient's Signature Date

CONSENT FORM

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by doctors of chiropractic employed at Beacon Family Chiropractic.

I have had an opportunity to discuss with a doctor of chiropractic or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, very rarely strokes (occurring less than 1,000,000 to 10,000,000 adjustments), dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the 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.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

FORMA DEL CONSENTIMIENTO

Solicito y consiento por este medio al functionamiento de los ajustes del chiropractico y de otros procedimientos del chiropractico, incluyendo varios modos de la fisiotherapia y de las radiographias de diagnostico, en mi (o en el paciente nombrado debajo, de quien soy legalmente responsible) por los doctores del chiropractico empleados por la Beacon Family Chiropractic.

He tenido unda oportunidad de discutir con un doctor del chiropractico o con el otro personal de la oficían o de la clinica la daturaleza y el proposito de los ajustes del chiropractico y de otros procedimientos. Entiendo que los resultados no estan garantizados.

Entiendo y fui informadas, como en las practica de la medicina, en las practica del chiropractic alli son algunos riesgos ao tratamiento, incluyendo pero no limitado a las fracturas, a lesions del disco, muy raramente a los movimientos, a las dislocaciones y a los esguinces (occure en menos de 1,000,000 a 10,000,000 ajustamientos). No espero que el doctor pueda anticipar y explicar todos los riesgos y complicaciones, y desco confiar en el doctor para ejercitar el juicio durante el curso del procedimiento que el doctor se siente en ese entonces, basedo sobre los hechos entonces sabiodos a el o a ella, estoy en mi major interes.

He leido, o he tenido leido a mi, el consentimenito, antedioho. Tambien he tenido una oprtunidad do hacer preguntas accrea de su contenido, y firmado abajo me convengo los procedimientos susodiachos. Pienso esta forma del consentimiento para curbrir el curso del tratamiento entero para mi actual condicion y para cualquier condicion(s) futo para el cual busque el tratamiento.

________________________________ ________________

Patient Name/Nombre de Patiente Date/Fetcha