Family Chiropractic SOLUTIONS

HIPPA Privacy Notice

This Notice is in effect as of 04/14/2003.

By signing below, I acknowledge that I have received and reviewed the HIPPA privacy notice and all of my questions have been answered to my satisfaction in language I can understand.

x_____ x_____

Print Name of Individual *Signature of Individual*

x_____ x_____

Signature of Legal Representative (e.g.: Attorney, Guardian, Parent) *Relationship of Legal Representative to Patient*

Date Signed _____ / _____ / _____ Witness: _____

Financial Policies

Family Chiropractic Solutions will do everything we can to bring out the best in you and your health, but we wish to make it very clear that your health is your responsibility. Please select the appropriate form of payment and sign your acknowledgment of our policy below.

_____ **CASH:** Payment is due at the time of service. Credit & Debit cards accepted.

_____ **INSURANCE PLAN:** Many insurance policies provide coverage for Chiropractic care. Benefits will vary from policy to policy and cannot be guaranteed until an EOB is received. We will contact your primary carrier to obtain benefits and process your claims. Any balance is your responsibility.

_____ **MEDICARE:** Payment is due at the time service is rendered. Exam, X-rays and supplements are a non covered service with Medicare. We file your charges to Medicare. We are considered non-assigned and therefore EOB's and/or payments made by Medicare will be sent directly to you.

_____ **MEDICAID:** Please present your current Medicaid card at time of service. For managed care plans, Aetna of Better Health of NE is accepted. United Healthcare does not cover our care. Visit limits and co-pays may apply.

_____**WC/ PI** Provide any reports & attorney information. WC-requires prior authorization.

I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I authorize the doctor to communicate with my primary care physician regarding my care. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature:_____ *Date*:_____

Family Chiropractic Solutions
Patient Information

Date: _____

Full Name: Mr. / Mrs. / Ms. _____
Last First Middle Initial

Address: _____
Residence & Mailing City State Zip Code

Age: _____ Birthdate: ____/____/____ ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced # of Children: _____

Social Security #: _____ Home #: _____ Cell #: _____

Email Address_____
Employer: _____ Occupation: _____

Employer Address: _____ Work #: _____

Spouses Name: _____

Spouses Employer: _____ Occupation: _____

Habits: Smoke ☐ None Pk/Day _____ Years _____

Alcohol ☐ None ☐ Social ☐ Light ☐ Moderate ☐ Heavy

Exercise ☐ None ☐ Occasionally ☐ Regular ☐ Time Per Week _____

Type of Exercise: _____

Hobbies/Leisure Activities:_____

_____

Work Activity is Mostly: ☐ Office/Clerical ☐ Light Labor ☐ Moderate Labor ☐ Heavy Labor

☐ Homemaker ☐Housework and Child Care

Major Problem or Complaint: _____

How does this impact your life? (Home, Relationships, Activities)

_____

_____

_____

Other Problems or Complaints: _____

List two Persons we may Contact in Case of Emergency (Not Living with You):

Relationship: _____ Name: _____ Phone #: _____

Relationship: _____ Name: _____ Phone #: _____

Health History

Name: _____ Height: _____ Weight: _____

Past Surgical History ☐ None

Please List Surgeries/Fractures	*Year*	*Doctor*
1.		
2.		
3.		
4.		

Serious Illnesses and Dates: ☐ None _____

Previous Injuries: ☐ None

Injury _____ How _____ Date _____ Treatment _____
Injury _____ How _____ Date _____ Treatment _____
Injury _____ How _____ Date _____ Treatment _____

Chiropractors you have seen: ☐ None

1. Name: _____ City: _____ Date: _____ For: _____
2. Name: _____ City: _____ Date: _____ For: _____

Current History

Present Medical Doctor: _____

Allergies: ☐ None _____

Current Medication: ☐ None List: _____

Current Health Problems: ☐ None List: _____

Do you have or have had? (If Yes, Circle and Explain) ☐ None

☐ Arthritis	☐ Kidney Disease	☐ Birth Control	☐ Cortisone Drug
☐ Cancer	☐ Diabetes	☐ Stomach Ulcers	☐ Asthma
☐ Heart Trouble	☐ High Blood Pressure	☐ Low Blood Pressure	☐ Stroke
☐ Tuberculosis	☐ Gall Bladder Problem	☐ Bleeding Tendency	☐ Thyroid Problem
☐ Headache	☐ Neurological Problems	☐ Migraine	☐ Depression
☐ Fever	☐ Chills	☐ Shortness of Breath	☐ Chest Pain
☐ Blurred Vision	☐ Dizziness	☐ Recent Weight Loss	☐ Mental Illness
☐ Recent Weight Gain			

Is there a Family History of? ☐ None

Mark all that apply:

	Cancer	Heart Disease	Diabetes	Arthritis	Other
Father	___	___	___	___	_____
Mother	___	___	___	___	_____
Brother	___	___	___	___	_____
Sister	___	___	___	___	_____

Print Name: _____ Date: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office:

1. Main Complaint: _____ When did the problem begin? _____

2. Second: _____ When did the problem begin? _____

3. Third: _____ When did the problem begin? _____

Balance Problems: ☐ YES ☐ NO
Bowel Problems: ☐ YES ☐ NO
Bladder Problems: ☐ YES ☐ NO
Weakness: ☐ YES ☐ NO
Where: _____

How Long does it Last?
- ☐ Constant
- ☐ On and off during the day
- ☐ Come and goes throughout week

Are your symptoms:
- ☐ Improving
- ☐ Getting Worse
- ☐ Same

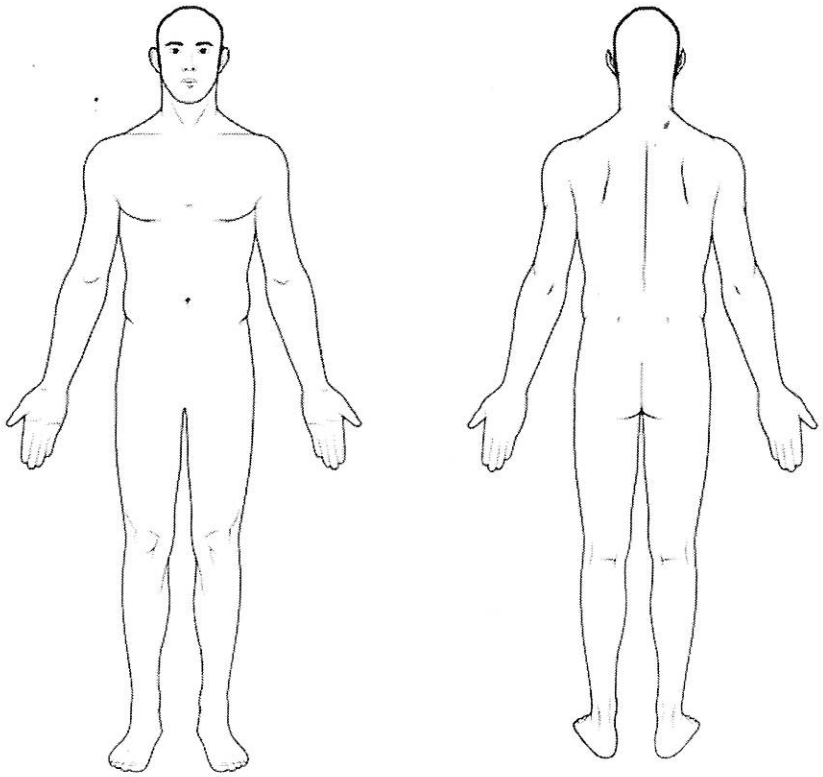
Time of Day it is Worse:
- ☐ Getting out of bed
- ☐ Morning
- ☐ Mid-day
- ☐ Evenings
- ☐ In bed at night
- ☐ Some all day

Is your problem a result of ANY type of accident? Yes/No
How did the injury happen?

_____

Have you had this symptom(s) before? Yes/No **When?** _____
Other Doctors seen for this problem? Yes/No **When?** _____
Treatment Received/Outcome: _____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
A = **A**ching **D** = **D**ull **S** = **S**harp/**S**tabbing **R** = **R**adiating **B** = **B**urning **N** = **N**umbness **T** = **T**ingling



What makes it worse?
- ☐ Lying Down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Lifting
- ☐ Twisting
- ☐ Looking Down/Up
- ☐ Looking Right/Left
- ☐ Bend Forward
- ☐ Bend Backward
- ☐ Sneeze/Cough
- ☐ Straightening Up
- ☐ Other: _____

What makes it better?
- ☐ Lying Down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Exercise
- ☐ Heat
- ☐ Cold Packs
- ☐ Straightening Up
- ☐ Nothing Relieves
- ☐ Other: _____

Name: _____ Date: _____

On a scale of **0 to 10** (0 being no pain and 10 being the worst pain), rate your complaints by circling the number:

1. Primary or **Main** Complaint: _____

What is your pain **RIGHT NOW**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your **TYPICAL** or **AVERAGE** pain? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level AT IT'S **BEST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level AT IT'S **WORST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

2. Second Complaint: _____

What is your pain **RIGHT NOW**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your **TYPICAL** or **AVERAGE** pain? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level AT IT'S **BEST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level AT IT'S **WORST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

3. Third Complaint: _____

What is your pain **RIGHT NOW**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your **TYPICAL** or **AVERAGE** pain? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level AT IT'S **BEST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level AT IT'S **WORST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

ACTIVITES OF LIFE

Name: _____ Date:_____

Please identify how your current conditions is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Lift Children/Objects	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Carry Children/Objects	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Exercise	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Up & Down Stairs	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentrate	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activites	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform