

Fax: 303.485.1924

Personal History

Name (First, Middle, Last)

Date: Social Security #

Birth date Age Sex: M F

Street Address City State Zip

Home Phone Cell Email

Business/Employer Type of Work

Emergency Contact Relationship Phone

How Did you hear about us?­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will you be paying cash for services? (for insurance see below)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information

Insurance Co. Name Member ID Group #

**Is accident related to Auto Accident**:Yes No

Date of Accident:

Claim # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe accident:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle your pain level (from 1 to 10, 1 being the lowest). 1 2 3 4 5 6 7 8 9 10.

How did this problem start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any Medication/Supplements currently taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had this problem or similar problem before? If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received any treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

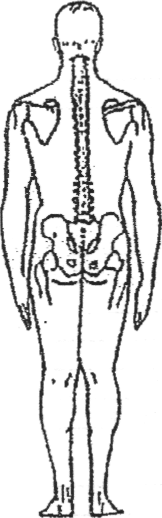
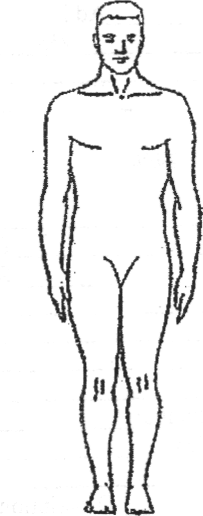
What improves symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any past surgery or injections: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any major hospitalizations/traumas:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark the exact location of your pain on this diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.**



**MAJOR** COMPLAINT

(Please Describe Only Major problems)

**Personal History**

Dizzy

Light Headed

Perfuse sweating

Migraine Headaches

Tension headaches

Neurological problems

(Parkinson's, paralysis)

Alzheimer's Disease

Arthritis

Carpal tunnel syndrome

Allergies/hay fever

Asthma

Reflux disease

Depression

Osteoporosis

Skin problems

**Chronic Illness**

Chronic fatigue synd

Cancer

Bronchitis

Autoimmune disease

Infection, chronic

Genetic disorder

Epilepsy

Emphysema

Colitis

Diverticular diseases

Fibromyalgia

Stroke

**ROS**

High Blood Pressure

Cholesterol elevated

Heart Disease

Circulatory problems

Diabetes

Glaucoma

Eating disorder

Eye, ear, nose, throat problems

Inflammatory bowel syndrome

Kidney or bladder disease

Liver or gallbladder disease (stones)

Urinary tract infection

Varicose veins

**Eating Habits.**

\_\_ one meal day

\_\_ Two Meals day

\_\_ three meals day

\_\_ number of snacks.

\_\_Smoker

\_\_ Alcohol intake per day

\_\_ Water intake per day

**Family Health History**

(Parents and Siblings)

\_\_Arthritis

\_\_Asthma

\_\_Alcoholism

\_\_Alzheimer's disease

\_\_Cancer

\_\_Depression

\_\_Diabetes

\_\_Drug addiction

\_\_Eating disorder

\_\_Genetic disorder

\_\_Glaucoma

\_\_Heart disease

\_\_Migraine headaches

\_\_Neurological disorders

(Parkinson's, paralysis)

\_\_Obesity

\_\_Osteoporosis

\_Stroke \_\_Suicide

Other.

**Medical (Men)**

\_\_Benign prostatic hyperplasia

\_\_Prostate cancer

\_\_Decreased sex drive

\_\_Infertility

\_\_Sexually transmitted disease

\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical (Women)**

\_\_Menstrual Irregularities

\_\_Endometriosis

\_\_Infertility

\_\_Fibrocystic Breasts

\_\_Fibroids/ovarian cysts

\_\_Premenstrual syndrome

\_\_Breast cancer

\_\_Pelvic Inflammatory disease

\_\_Vaginal infections

\_\_Decreased sex drive

**Exercise.**

\_\_ 1-3 times week

\_\_ 3-6 times week

\_\_ 15-30 minutes

\_\_ 30-60 minute

Please list any other major health complications/issues/surgeries/traumas/diagnoses not stated above. List below.

**HIPAA Information and Consent Form**

HIPPA Information

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been in practice for years. This form is a “friendly” version. A more complete version is available at your request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional services and care. Additional information is available from the U.S. Department of Health and Human Services. www. hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored to open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of chars, patient records, PHI and other documents or information**.**
2. It is the policy of this office not to do appointment reminder calls, but if a telephone message needs to be left, your PHI is not included. Records requests by patients are only available to pick up in person or U.S. mail.
3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or Insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning you PHI. However, we are not obligated to alter internal policies to conform to your request.

I (printed name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do hereby consent and acknowledge my agreement to the terms set forth above (regarding HIPPA) and any subsequent change in office policy. I understand that this consent shall remain in force from this time forward.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent Related to Privacy Notice:**

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

**Consent for Care:**

I, with my signature, authorize Firestone Chiropractic, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, and palliative care. This consent includes contact and discussion with other health care professionals for care and treatment.

* By Signing this I agree that I have read and understand the Consents as stated above:

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_