Patient Data Date: _____

Title: ☐Mr. ☐Mrs. ☐Ms ☐Miss (check one)

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address Line 1: _____

Address Line 2: _____

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

Home Phone: (_____)_____-_____ **Work Phone:** (_____)_____-_____

Cell Phone: (_____)_____-_____

Date of Birth: _____/_____/_____ **Sex:** ☐Male ☐Female **Email:** _____

Social Security Number: _____-_____-_____ **Marital Status:** ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other (check one)

Spouse Data

Is your spouse a patient in the clinic? ☐Yes ☐ No

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Home Phone: (_____)_____-_____ **Work Phone:** (_____)_____-_____

Employer Data

Name: _____

Address Line 1: _____

Address Line 2: _____

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

Emergency Contact

Contact Name: _____

Contact Phone: (_____) _____-_____

Is it okay to call you at work?

❑ Yes ❑ No

How did you hear about our clinic? Or who referred you?

❑ Family member	❑ Attorney	❑ Internet web site	❑ Health class
❑ Friend	❑ Yellow Pages	❑ Billboard	❑ Brochure
❑ Physician	❑ Newspaper ad	❑ TV Commercial	❑ Direct mail ad
❑ Employer	❑ Sign on building	❑ Radio	❑ Other

If you selected 'Yellow Pages' please indicate which Yellow Pages:

_____ _____ _____ _____

If you selected 'family member', 'friend', or 'physician' please enter their name below:

_____

If you selected 'other' please describe

_____

Medical Conditions:

❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Heart Disease
❑ Hypertension	❑ Psychiatric Illness	❑ Skin Disorder	❑ Stroke

Surgeries:

❑ Appendectomy	❑ Cardiovascular procedure	❑ Cervical disc procedure	❑ Hysterectomy
❑ Joint replacement	❑ Laminectomies	❑ Radical prostatectomy	❑ Transuretheral prostate surgery

Allergies:

❑ Eggs	❑ Fish and Shellfish	❑ Milk or Lactose	❑ Peanut
❑ Soy	❑ Sulfites	❑ Wheat/Gluten	

Social History:

❑ Caffeine used occasionally	❑ Caffeine used often	❑ Chew tobacco occasionally	❑ Chew tobacco often
❑ Drink alcohol occasionally	❑ Drink alcohol often	❑ Exercise not at all	❑ Exercise occasionally
❑ Exercise often	❑ Experience stress occasionall	❑ Experience stress often	❑ Smoke 1 pack or less per day
❑ Smoke more than 1 pack a day	❑ Wear seat belts always	❑ Wear seat belts never	❑ Wear seatbelts usually

Family History:

❑ Arthritis (parent)	❑ Arthritis (sibling)	❑ Cancer (parent)	❑ Cancer (sibling)
❑ Cholesterol (parent)	❑ Cholesterol (sibling)	❑ Diabetes (parent)	❑ Diabetes (sibling)
❑ Heart problems (parent)	❑ Heart problems (sibling)	❑ High blood pressure (parent)	❑ High blood pressure (sibling)
❑ Psychiatric (parent)	❑ Psychiatric (sibling)	❑ Stroke (parent)	❑ Stroke (sibling)
❑ Thyroid (parent)	❑ Thyroid (sibling)		

Substance Use:

❑ Alcohol (past)	❑ Alcohol (present)	❑ Amphetamines (past)	❑ Amphetamines (present)
❑ Barbiturates (past)	❑ Barbiturates (present)	❑ Cocaine (past)	❑ Cocaine (present)
❑ Crystal Meth (past)	❑ Crystal Meth (present)	❑ Heroine (past)	❑ Heroine (Present)
❑ Marijuana (past)	❑ Marijuana (present)		

Male Children:

❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Female Children:

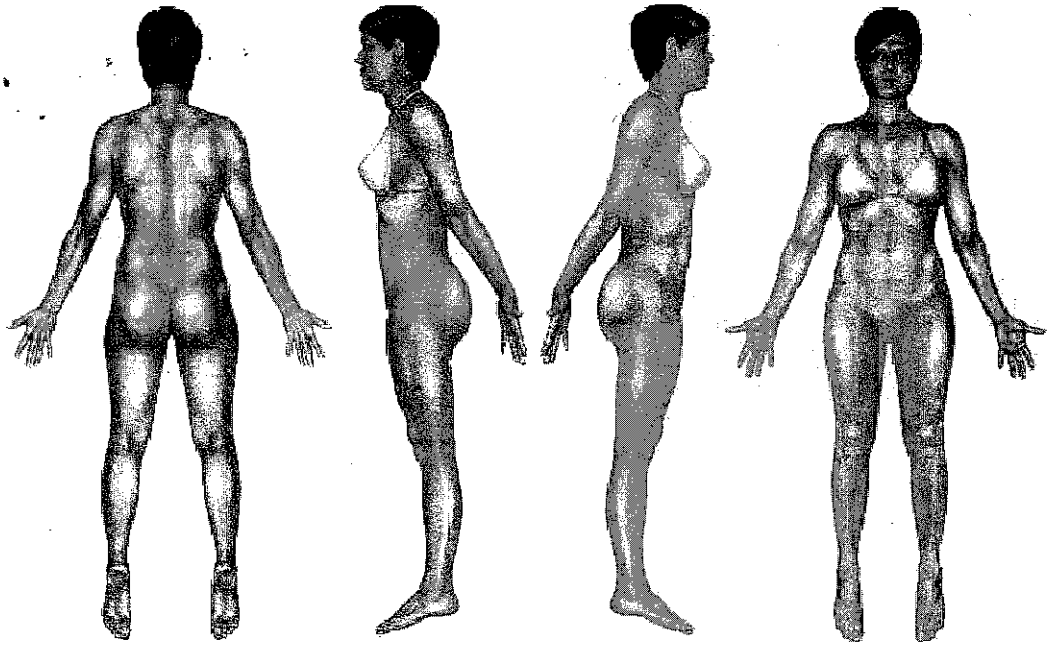
❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Occupational Activities:

❑ Administration	❑ Business owner	❑ Clerical/secretarial	❑ Computer user
❑ Construction	❑ Daycare/childcare	❑ Executive/legal	❑ Food service industry
❑ Health care	❑ Heavy equipment operator	❑ Heavy manual labor	❑ Home services
❑ Household	❑ Light manual labor	❑ Manufacturing	❑ Medium manual labor

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness **X = Burning** **/ = Stabbing** **0 = Pins & Needles** **+ = Dull Ache**



Describe your symptoms:_____

_____

When did your symptoms start? Month_____ **Day**_____ **Year**_____

How did your symptoms begin?_____

_____

How often do you experience your symptoms?

- ❑ Constantly (76-100% of the day)
- ❑ Frequently (51-75% of the day)
- ❑ Occasionally (26-50% of the day)
- ❑ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ❑ Sharp
- ❑ Dull ache
- ❑ Numb
- ❑ Shooting
- ❑ Burning
- ❑ Tingling
- ❑ Stabbing

How are your symptoms changing?

- ❑ Getting better
- ❑ Not changing
- ❑ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- ❑ 0 None
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- ❑ 9
- ❑ 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

- ❑ Not at all
- ❑ A little bit
- ❑ Moderately
- ❑ Quite a bit
- ❑ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ A little of the time
- ❑ None of the time

In general, would you say your overall health right now is....

❑ Excellent ❑ Very good ❑ Good ❑ Fair
❑ Poor

Who have you seen for your symptoms:

❑ No one ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

What treatment did you receive for your symptoms?

❑ Adjustments ❑ Physical Therapy ❑ Medication ❑ Surgery
❑ Other

When did you receive this treatment?

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 – 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

What tests have you had for your symptoms?

❑ X-rays ❑ MRI ❑ CT Scan ❑ Other

When were these tests done?

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 - 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

Have you had similar symptoms in the past?

❑ Yes ❑ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

❑ This Office ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

What is your occupation?

❑ Professional/Executive ❑ White Collar/Secretarial ❑ Tradesperson ❑ Laborer
❑ Homemaker ❑ Full-time Student ❑ Retired ❑ Other

If you are not retired, a homemaker or a student, what is your work status?

❑ Full-time ❑ Part-time ❑ Self-employed ❑ Unemployed
❑ Off work ❑ Other

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:
Name of Recipient(s): _____
Relationship to the Patient: _____

I give authorization to disclose the following information:

- All treatment information
- Information specifically related to these treatment dates
  Starting Date: _____ End Date: _____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying Boone Family Chiropractic in writing.

Signature of Patient (or Patient Representative) _____ Date: _____
Printed Name of Patient (or Patient Representative) _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Boone Family Chiropractic
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Boone Family Chiropractic's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____ _____
Signature of Patient or Personal Representative **Name of Patient or Personal Representative**

_____ _____
Date **Description of Personal Representative's Authority**

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as"Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

If you have any questions for the Doctor, you may wait to sign this form until all questions have been answered.

DATE _____ _____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)