# Confidential Health Data

Please allow our staff to photocopy your driver's license and insurance details. If you need any assistance completing this form, please ask the assistants at the front desk. All information you supply is confidential. Please print clearly.

Eastgate CHIROPRACTIC

Date _____ **Whom can we thank for referring you?** _____

Primary Physician's Name _____ ❑Yellow Pages ❑ Mail ❑ Location ❑ Internet

and Location _____ ❑Other: _____

Previous Chiropractor's Name _____ Last visit date _____

## PATIENT INFORMATION

Social Security Number _____

Name _____ Date of Birth _____ ❑ Male ❑ Female

Marital Status ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

Spouse's Name _____

Number of Children _____

Mailing Address _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Work _____

Email _____ Preferred Contact Method ❑ Home ❑ Cell ❑ Work ❑ email

Occupation _____ Employer _____

Emergency Contact _____ Phone _____

Payment for Services will be by ❑Cash ❑Check ❑Credit Card ❑Health Insurance ❑Car Insurance ❑Work Comp

Insurance Company _____ Policy/Claim Number _____

Insured's Social Security Number _____ Insured's Date of Birth _____

Are you covered by more than one insurance company? ❑Yes ❑No

## Medical/Family History

S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes)

| S | M | F | | S | M | F | | S | M | F | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | AIDS | ❑ | ❑ | ❑ | dislocated joints | ❑ | ❑ | ❑ | neck pain |
| ❑ | ❑ | ❑ | anemia | ❑ | ❑ | ❑ | epilepsy | ❑ | ❑ | ❑ | nervousness |
| ❑ | ❑ | ❑ | arthritis | ❑ | ❑ | ❑ | German measles | ❑ | ❑ | ❑ | numbness |
| ❑ | ❑ | ❑ | asthma | ❑ | ❑ | ❑ | headaches | ❑ | ❑ | ❑ | polio |
| ❑ | ❑ | ❑ | back pain | ❑ | ❑ | ❑ | heart trouble | ❑ | ❑ | ❑ | poor circulation |
| ❑ | ❑ | ❑ | bladder trouble | ❑ | ❑ | ❑ | reproductive disorders | ❑ | ❑ | ❑ | hepatitis |
| ❑ | ❑ | ❑ | bone fracture | ❑ | ❑ | ❑ | high blood pressure | ❑ | ❑ | ❑ | rheumatic fever |
| ❑ | ❑ | ❑ | cancer | ❑ | ❑ | ❑ | HIV/ARC | ❑ | ❑ | ❑ | rheumatism |
| ❑ | ❑ | ❑ | chest pain | ❑ | ❑ | ❑ | kidney disorder | ❑ | ❑ | ❑ | scarlet fever |
| ❑ | ❑ | ❑ | concussion | ❑ | ❑ | ❑ | bowel control loss | ❑ | ❑ | ❑ | serious injury |
| ❑ | ❑ | ❑ | convulsions | ❑ | ❑ | ❑ | menstrual cramps | ❑ | ❑ | ❑ | sinus trouble |
| ❑ | ❑ | ❑ | diabetes | ❑ | ❑ | ❑ | multiple sclerosis | ❑ | ❑ | ❑ | tuberculosis |
| ❑ | ❑ | ❑ | indigestion | ❑ | ❑ | ❑ | muscular dystrophy | ❑ | ❑ | ❑ | venereal disease |

Have you ever had a metal implant? ❑ Yes ❑ No Have you ever been gunshot? ❑ Yes ❑ No

## Surgical History (list past surgeries and dates performed, use a separate sheet if necessary)

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

## Accident History (Is todays visit related to an accident? ❑ Yes ❑ No - ❑ Auto ❑ Work ❑ Other_____)

❑ Job ❑ Auto ❑ Other Area Affected _____ Date _____

❑ Job ❑ Auto ❑ Other Area Affected _____ Date _____

❑ Job ❑ Auto ❑ Other Area Affected _____ Date _____

Initials _____

Have you been treated by a physician for any health condition in the last year? ❑ Yes ❑ No

Describe Condition _____ Date of Last Physical Exam _____

**Reason For Today's Visit** (List all ***SYMPTOMS*** and rate them on a pain scale 0-10, 0 = no pain 10 = sever pain)

1. _____ 0 1 2 3 4 5 6 7 8 9 10
2. _____ 0 1 2 3 4 5 6 7 8 9 10
3. _____ 0 1 2 3 4 5 6 7 8 9 10
4. _____ 0 1 2 3 4 5 6 7 8 9 10
5. _____ 0 1 2 3 4 5 6 7 8 9 10
6. _____ 0 1 2 3 4 5 6 7 8 9 10

Symptoms are worse in the ❑ Morning ❑ Afternoon ❑ Night Symptoms/Complaints ❑ Come & Go ❑ Are Constant

Symptoms Developed From: ❑ Auto Accident ❑ Work Injury ❑ Injury ❑ Illness ❑ Gradual Onset ❑ Unknown Origin

Symptoms Have Persisted For (number) ____Hour(s) ____Day(s) ____Week(s) ____Month(s) ____Year(s)

Have you ever had this before? ❑ No ❑ Yes if Yes, When was the last episode? _____

**Onset** (When did your symptoms start) _____

**Aggravating Factors** ❑ Bending ❑ Reaching ❑ Bowel Movements ❑ Lifting ❑ Coughing ❑ Sitting ❑ Turning Head ❑ Sneezing ❑ Walking ❑ Lying Down ❑ Standing ❑ Other _____

**Relieving Factors** ❑ Bending ❑ Heat ❑ Ice ❑ Lifting ❑ Lying Down ❑ Meds ❑ Reaching ❑ Resting ❑ Sitting ❑ Standing ❑ Stretching ❑ Turning Head ❑ Walking ❑ Other _____

**Prior Treatment** ❑ Chiropractic ❑ Massage ❑ Acupuncture ❑ Ice ❑ Heat ❑ Homeopathic ❑ Prescription Meds ❑ Over-the-Counter Meds ❑ Surgery ❑ Surgery Doctors seen:_____

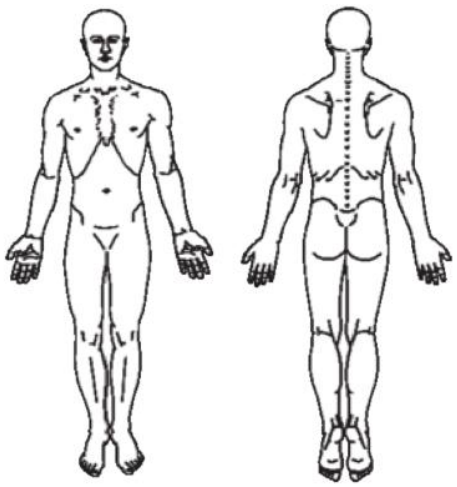
**Quality of Symptoms**

- ❑ Burning
- ❑ Grabbing
- ❑ Tightness
- ❑ Soreness
- ❑ Sharp
- ❑ Dull
- ❑ Stiffness
- ❑ Tingling
- ❑ Other
- ❑ Aching
- ❑ Stabbing
- ❑ Tenderness
- ❑ Numbness

**Radiation** (to what areas do the symptoms travel)

_____

**Location** (Where does it hurt?) Circle the area(s) on the diagram "X" for current condition/"O" for past conditions



Are You Allergic To Any Medications ❑ No ❑ Yes _____

Medications Currently Taking _____

Are You Pregnant? ❑ No ❑ Yes Date of Last Menstrual Period _____

Check Any Additional Symptoms You May Be Having

- ❑blurred vision
- ❑buzzing in ears
- ❑cold feet
- ❑cold hands
- ❑cold sweats
- ❑concentration loss /confusion
- ❑constipation
- ❑depression /weeping spells
- ❑diarrhea
- ❑dizziness
- ❑face flushed
- ❑fainting
- ❑fatigue
- ❑fever
- ❑head seems too heavy
- ❑headaches
- ❑insomnia
- ❑light bothers eyes
- ❑loss of balance
- ❑loss of smell
- ❑loss of taste
- ❑low resistance to colds
- ❑muscle jerking
- ❑numbness in fingers
- ❑numbness in toes
- ❑pins and needles in arms
- ❑pins and needles in legs
- ❑ringing in ears
- ❑shortness of breath
- ❑stiff neck
- ❑stomach upset

Initials_____

## Review of Systems

| | Yes | No | | Details |
|---|---|---|---|---|
| General | ❑ | ❑ | Recent weight loss or weight gain | |
| Skin | ❑ | ❑ | Rashes, hives or lesions | |
| HEENT | ❑ | ❑ | Hay fever or post nasal discharge | |
| Cardiovascular | ❑ | ❑ | Chest pain or palpitations | |
| Pulmonary | ❑ | ❑ | Shortness of breath, wheezing or coughing | |
| Gastrointestinal | ❑ | ❑ | Nausea, vomiting, constipation or diarrhea | |
| Genitourinary | ❑ | ❑ | Changes in Urination Frequency or Urgency | |
| Lymphatic | ❑ | ❑ | Lymphadenopathy | |
| Endocrine | ❑ | ❑ | Polyuria or polydipsia | |
| Neurological | ❑ | ❑ | History of seizures or headache | |

## Social History

| | | | | |
|---|---|---|---|---|
| Tobacco usage | ❑ None | ❑ Light | ❑ Moderate | ❑ Heavy |
| Alcohol usage | ❑ None | ❑ Light | ❑ Moderate | ❑ Heavy |
| Drug Usage | ❑ None | ❑ Light | ❑ Moderate | ❑ Heavy |
| Exercise | ❑ Never | ❑ Seldom | ❑ Occasional | ❑ Regularly |

### Acknowledgements

To set clear expectations, improve communication and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

**I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health including various modes of physiotherapy and chiropractic adjustments. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

**I have had an opportunity to discuss with the doctor or with other office/clinic 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, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all 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 to cover the entire course of treatment**

Initials _____ **for my present condition and for any future condition(s) for which I seek treatment.**

**I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected**

Initials _____ **and released on my behalf for seeking reimbursement from any involved third parties.**

**I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or**

Initials _____ **health information to me as an extension of my care in this office.**

**I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the**

Initials _____ **payment of any covered or non-covered services I receive.**

**To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence,**

Initials _____ **severity or cause of my health concern.**

If the patient is a dependent, print dependent's full name:_____

Signature_____Date_____

Julie Fisher D.C.
Joseph Hall D.C.

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

***Summary:***

By law, we are required to provide you with our Notice of Privacy Practices (NPP).
This Notice describes how your medical information may be used and disclosed by us.
It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice: 06-20-2005
Contact Person: Ashley Konrad
Phone Number: (208) 743-0231

***Acknowledgement of Notice of Privacy Practices***

*"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way".*

_____

Patient or Representative Name (Please Print)

_____

Patient or representative Signature Date

- ☐ Patient refused to sign
- ☐ Patient was unable to sign because_____