Patient Information Form

HIPPA
Protected Health Information
Authorized Access Only

First Name: _____ MI_____ Last Name_____

Permanent Address: _____City: _____State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____ Email: _____

Preferred Method of Contact: (Please Circle One) Home Ph, Work Ph, Cell Ph, Email, Other_____

Date of Birth: _____ Sex: Male___ Female___ SSN: _____

Marital Status: S M D W Occupation:_____ Employer: _____

Spouse's Name: _____ DOB: _____

Employer: _____ Work Phone: _____

Updated Patient Information

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Race: ☐ I do not wish to provide this information
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ Other _____

Ethnicity: ☐ I do not wish to provide this information
☐ Hispanic or Latino
☐ Non-Hispanic or Non-Latino
☐ Other_____

Smoking Status: ☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker
☐ Never smoker

Do you have any medication allergies? ☐ No known medication allergies
☐ Yes. What_____

Are you currently taking any medications? ☐ Not currently prescribed any medications
☐ Yes. What? _____ _____mg or mcg _____ _____mg or mcg

_____ _____mg or mcg _____ _____mg or mcg

Name of last Chiropractor: _____

Name of last MD: _____

How did you hear about our office?
_____Internet _____ Newspaper _____ Radio _____ Personal Referral: Whom may we thank? _____

☐ Work Injury ☐ Auto Accident ☐ Other Accident

I understand that (regardless of my insurance status) I am ultimately responsible for this balance on my account for all professional services rendered.
I understand that I am responsible to determine my insurance benefits. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ _____
Signature Date

If Patient is a minor
Parents/Guardian Name: _____

_____ _____
Parent/Guardian Signature if minor Date

Office Use Only-PLEASE DO NOT FILL OUT

Age_____
Vital Signs: BP_____/_____ L/R ☐ Supine ☐ Seated ☐ Standing
Height_____ Weight_____ Pulse_____ Resp_____ Temp_____
Dynanometer (Kgs): R_____/_____/_____ L_____/_____/_____

Vision: R_____/20 L_____/20 Oswestry: CSpine_____ LSpine_____ General_____

Patient History

Name: _____ Date: _____

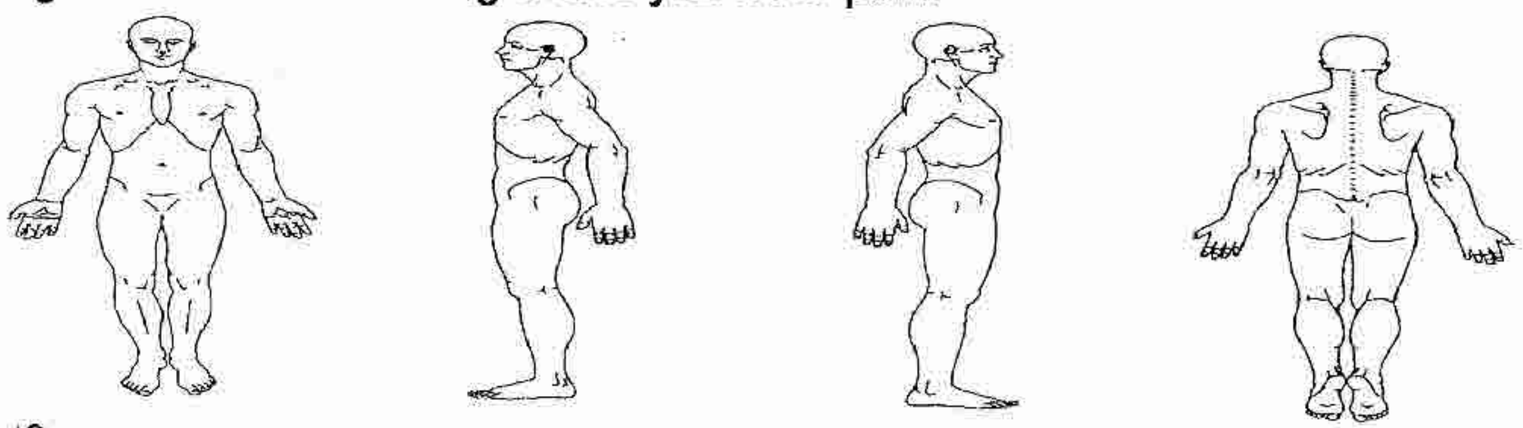
What brings you into the office today? _____

_____

Please answer the following questions as completely as possible:

Where is your pain? _____

Draw on the diagrams below indicating where you have pain.



When did it start? _____

How did it happen? _____

This complaint came on: ☐Gradually ☐Immediately
This complaint is: ☐Improving ☐Staying the same ☐Getting worse
The intensity of this complaint is: ☐Minimal ☐Slight ☐Moderate ☐Severe
The frequency of this complaint is: ☐Occasional ☐Frequent ☐Constant
The pain is: ☐Dull ☐Sharp ☐Aching ☐Shooting ☐Spasm ☐Throbbing ☐Burning ☐Tingling

Have you seen another doctor for this problem? __ yes __ no Whom? _____

Have you had any diagnostic tests (x-ray, lab, MRI, etc.) for this condition? _____

_____

Have you had any of the following disease/medical condition(s)?

Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones/Joints	Y N Arthitis

	The following are activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?	Yes, Limited A lot	Yes, Limited a Little	No, Not Limited
3	Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports			
4	Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
5	Lifting or carrying groceries			
6	Climbing several flights of stairs			
7	Climbing one flight of stairs			
8	Bending, kneeling, or stooping			
9	Walking more than a mile			
10	Walking several blocks			
11	Walking on block			
12	Bathing or dressing yourself			

OVER ⟶

Please rate your pain from 0 to 10 (10 being the highest possible level of pain) for only the areas of concern.

	LEVEL OF PAIN										
Overall Condition	0	1	2	3	4	5	6	7	8	9	10
Headache	0	1	2	3	4	5	6	7	8	9	10
TMJ	0	1	2	3	4	5	6	7	8	9	10
Chest	0	1	2	3	4	5	6	7	8	9	10
Abdomen	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Mid back	0	1	2	3	4	5	6	7	8	9	10
Low back	0	1	2	3	4	5	6	7	8	9	10

UPPER EXTREMITIES

	RIGHT											LEFT										
Shoulders	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Arms	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Elbows	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Forearms	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Wrists	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Hands	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Fingers	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

LOWER EXTREMITIES

	RIGHT											LEFT										
Hip	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Thighs	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Knees	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Shins	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Ankles	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Feet	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Toes	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

Brookings Chiropractic Center
Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Brookings Chiropractic Center to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient at Brookings Chiropractic Center.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff within the facility of Brookings Therapeutic and Surgery Center has been trained in the area of patient records privacy and a privacy official has been designated to enforce those procedures. Common storage of all PHI for the Brookings Chiropractic Center and the Brookings Ambulatory Surgery Center provides one secure location within the facility. We have taken all precautions known by this office to assure your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Patient/Parent/Guardian Signature Date

I, _____, authorize Brookings Chiropractic Center to discuss my condition and account information with any of the following person or persons list below.

_____, _____, _____

_____

Patient/Parent/Guardian Signature Date