Hausman Chiropractic & Acupuncture

Patient Health Questionnaire

Date:_____ **Patient No.** _____

Patient Name (Legal): _____ **Date of Birth:**_____

Nickname (If any): _____ **SSN #:** _____

Home Address:_____ **Apt.#:** _____

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

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail Address: _____

Would you like to receive text message appointment reminders? □ **Yes** □ **No**

If yes, what is your mobile service provider? _____

***(Normal messaging rates may apply, based on your service plan)**

Employer: _____ **May we contact you at work?** □ **Yes** □ **No**

Marital Status: □ **Single** □ **Married / Domestic Partnership** □ **Widowed**

Name of Spouse: _____ **Number of Children:**_____

Emergency Contact: _____ **Phone Number:** _____

Who is your family doctor? _____

How were you referred to our clinic? _____

FINANCIAL/INSURANCE POLICY

I understand and agree that health/accident insurance policies are an agreement between an insurance carrier and myself. I understand that my insurance will be billed for services rendered in this office and that I am responsible for any services not paid and/or not covered by my insurance. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and any fees for collection of past due accounts. I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered to me will be immediately due and payable.

Patient Signature:_____ Date:_____

History of Present Injury

Patient Name: _____ Date: _____

What are your goals for treatment in our office? ☐ Short-term Relief ☐ Long-term Relief ☐ Wellness/Preventative Care

Have you been to a chiropractor before? ☐ YES ☐ NO

1. List Your Current Complaints (from most to least severe) **& Rate Your Pain Intensity** (scale of 0 – 10 with 10 being the worst)

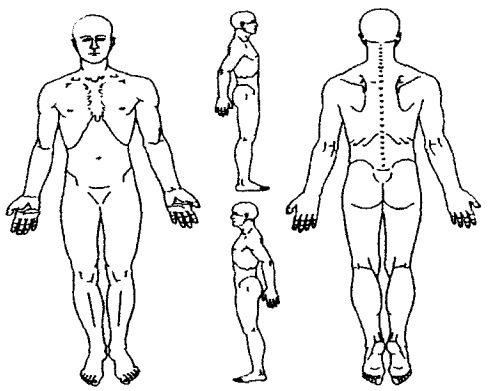
#1.)_____ Pain Rating ☐ #2.)_____ Pain Rating ☐

#3.)_____ Pain Rating ☐ #4.)_____ Pain Rating ☐

a. Quality of Pain
- ☐ Sharp
- ☐ Dull
- ☐ Achy
- ☐ Numb
- ☐ Tingling
- ☐ Shooting
- ☐ Weakness
- ☐ Gripping
- ☐ Burning
- ☐ Throbbing

b. Frequency
- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25% or less)

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR RELATED SYMPTOMS.



c. Are your symptoms? ☐ Increasing ☐ Decreasing ☐Not Changing

d. What time of day are your symptoms worse? ☐ Morning ☐ Afternoon ☐ Night ☐ Same All Day ☐_____

2.) When did your problem begin? (Specific date if possible) _____ How did your problem begin? _____

3.) What makes your problem **BETTER?** ☐ Nothing ☐ Rest ☐ Walking ☐ Standing ☐ Sitting ☐ Movement ☐_____

4.) What makes your problem **WORSE?** ☐ Nothing ☐ Rest ☐ Walking ☐ Standing ☐ Sitting ☐ Movement ☐_____

5.) Do you find it difficult when? ☐ Walking ☐ Standing ☐ Sitting ☐ Bending ☐ Lifting ☐ Riding ☐ Working ☐_____

6.) Have you taken any medications for this condition?_____

Have they helped? ☐ Yes ☐ No ☐ Somewhat

7.) Have you been treated elsewhere for **THIS EPISODE?** ☐ Yes ☐ No

If yes, by whom? ☐ Chiropractor ☐ M.D. ☐ Osteopath ☐ Physical Therapist ☐ Massage Therapist ☐ Other _____

What treatment was performed? _____ Did it help? ☐ Yes ☐ No ☐ Somewhat

What was their diagnosis?_____

8.) What would you rate your general stress level? ☐ Little or no stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

9.) Physical activity at work: ☐ Sitting more than 50% of day ☐ Light manual labor ☐ Heavy manual labor ☐ Repeated motion

10.) Occupation: _____ ☐ FT ☐ PT Has your work status changed because of this complaint? ☐ Yes ☐ No

Doctor's Additional Comments/General Health Concerns:

_____

_____

_____

_____

_____

_____

Past Medical History

If you have ever had a listed condition in the past, please check it in the **Past** column. If you are presently troubled by a particular condition, check it in the **Present** column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

Present **Weight** _____ lbs. **Height** _____ ft. _____ in.

Past	Present	
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Wrist Pain (719.43)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joint (719.0)
☐	☐	Fainting (780.2)
☐	☐	Visual Disturbances (368.9)
☐	☐	Convulsions (780.3)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Tinnitus (Ear Noises) (388.30)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (786.50)
☐	☐	Loss of Appetite (783.0)
☐	☐	Anorexia (307.1)
☐	☐	Abnormal Weight
☐	☐	Excessive Thirst (783.05)
☐	☐	Chronic Cough (786.2)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	General Fatigue (780.7)
☐	☐	Irregular Menstrual Flow (626.04)
☐	☐	Profuse Menstrual Flow (626.7)
☐	☐	Breast Soreness/Lumps (611.72)
☐	☐	Endometriosis (617.9)
☐	☐	PMS (625.4)
☐	☐	Loss of Bladder Control (788.30)
☐	☐	Painful Urination (788.1)
☐	☐	Frequent Urination (788.41)
☐	☐	Abdominal Pain (789.0)
☐	☐	Constipation/Irregular bowel habits (564.0)
☐	☐	Difficulty in Swallowing (787.2)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Dermatitis/Eczema/Rash (692.9)
☐	☐	Depression (311)
☐	☐	Aortic Aneurysm (441.50)
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (435)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Tumor (229.9)
☐	☐	Prostate Problems (601.9)
☐	☐	Blood Disorder (790.6)
☐	☐	Diabetes (250.0)
☐	☐	Emphysema (526.9)
☐	☐	Arthritis (716.9)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Systemic Lupus (710.0)
☐	☐	Epilepsy (349.5)
☐	☐	Ulcer (556.9)
☐	☐	Liver (573.9)/Gallbladder (575.9) Problems
☐	☐	Hepatitis (573.3)
☐	☐	Kidney Stones (592.0)
☐	☐	Kidney Disorders (by condition)
☐	☐	Bladder Infection (595.9)
☐	☐	Colitis (558.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042)
☐	☐	Allergies _____
☐	☐	Other _____
☐	☐	Other _____

If a **family member** has had any of the following please mark the appropriate box and list the relationship.

☐	Cancer	_____
☐	Rheumatoid Arthritis	_____
☐	Lupus	_____
☐	Diabetes	_____
☐	Heart Problems	_____
☐	Lung Problems	_____
☐	High Blood Pressure	_____
☐	Epilepsy	_____
☐	Chronic Back Pain	_____
☐	Chronic Headache	_____
☐	Other	_____

Do you have a permanent disability rating? ☐ Yes ☐ No
Body Region: _____
Date rating received: ____/____/____
Rating Percentage: _____%

Please check any of the following that apply to you.

Past	Present	
☐	☐	Pregnancy (V22.2)
☐	☐	Birth Control Pills
☐	☐	Hormonal/Estrogen Replacement
☐	☐	Medications (if not listed elsewhere)
		_____
		_____
		_____
☐	☐	Hospitalization/Surgical Procedures
		_____
		_____
		_____
☐	☐	Tobacco (305.1)
☐	☐	Alcohol (305.0)
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Coffee/Tea/Caffeinated Soft Drinks: cups/cans per day _____

Females: Are you currently pregnant? _____

Doctor's Additional Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Vital Signs:

Blood Pressure: _____

Pulse: _____

X-Rays Ordered:

_____
_____

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) CONSENT FORM

In the course of your care as a patient at our office, we may use or disclose personal and health related information about you in the following ways: 1.) Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. 2.) Your health records as well as your billing records may be disclosed to another party, such as insurance carrier (HMO, PPO, etc.) or your employer (only if they are responsible for payment). Under federal law, we are also permitted to use or disclose your health information without your consent or authorization in the following circumstances:

* If we are providing health care services to you based on the orders of another health care provider.
* If we provide health care services to you in an emergency.
* If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
* If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. Your name, address, phone number, and your health records may be used to contact you regarding appointment reminder, a message may be left on your answering machine. We may also mail information to you regarding your health care or about the status of your account. By signing below, I acknowledge that I have read the above information.

***Please note changes to HIPAA laws that went into effect 9/1/13.**
A copy of these Federal Privacy Laws are available at your request.

We will not release your personal health care information without prior written consent.

Patient Signature:_____ Date:_____

INFORMED CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedure, chiropractic care or any clinic services that he deems necessary in my case; and I further authorize him to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services, companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer.

It is not enough that you understand the benefits of chiropractic care in restoring normal joint motion and nervous system health, you must also be aware of the existence of inherent risks and limitations to chiropractic care. Every type of treatment (medical, chiropractic or otherwise) carries some form of potential risk associated with it. Risks associated with some forms of chiropractic care include muscular sprain/strain, neurological deficit, osseous fracture and vertebral artery dissection. While the incidence of injury from chiropractic care is extremely low, and only seldom are the risks great enough to contraindicate care, these facts should be considered in making the decision the receive chiropractic care.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the potential risks of chiropractic care; including the risk that care I receive in this office may not accomplish the desired clinical objective. I have been advised of reasonable alternative treatments, including known risks, consequences, and probable effectiveness of each, and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been provided to me concerning the results of the care I will receive. I knowingly authorize Hausman Chiropractic and Acupuncture to proceed with chiropractic care and treatment.

Patient Signature:_____ Date:_____