Absolute Healthcare Advanced Chiropractic

WELCOME

The doctors and staff of Absolute Healthcare Advanced Chiropractic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we will be able to assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient and will refer you to another health care provider, if appropriate.

Today's Date:_____ Patient's Social Security # _____
First Name: _____ M.I. _____ Last Name: _____
Date of Birth: _____ Sex: __M __F What do you like to be called:_____
Address: _____
City:_____ State:_____ Zip Code: _____
Home Phone: (_____)_____ Work Phone: (_____)_____ ext. _____
Cell Phone: (_____)_____ (Other)_____ : (_____)_____
Which Phone would you prefer us to contact you with (circle)? home work cell
May we leave voice mails/messages and/or appointment reminders on this phone (circle)? Yes No

Marital Status: __Single __Married __Other
E-mail (optional): _____
Occupation (optional): _____ Employer (optional): _____

How did you find out about us?: (Check all that apply)
__Friend / Family Member (Name)_____
__Website
__ Online Advertisement (please list Web site)_____
__Clinic Location _____Postcard _____Insurance Directory
__Advertisement (plese tell us which publication or location)_____
__Other (Please Describe)_____

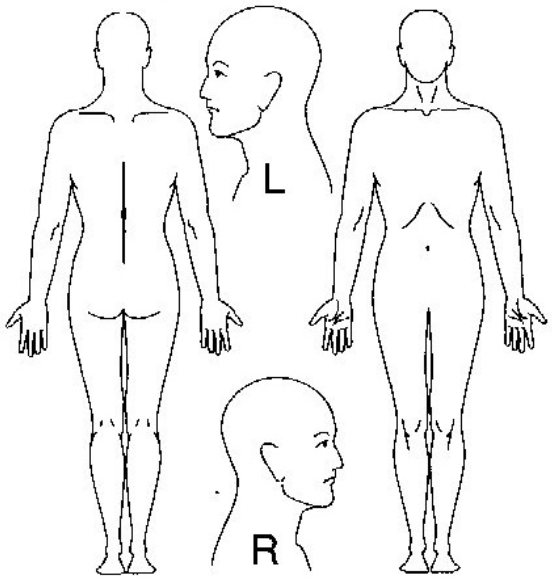
Payment for Services will be: __Health Insurance __Cash/Check/Credit Card__Auto Accident __Worker's Compensation

Please describe your major complaints:
Please describe each pain or symptom that you are having and **place an X on the severity of pain line** to indicate the level of discomfort that the pain/symptom creates: 1 being no pain, and 10 being the worst pain you can imagine:

Symptom Description	**Severity of Pain (10 being the worst)**
1. _____	1 ----------5----------10
2. _____	1 ----------5----------10
3. _____	1 ----------5----------10

Mark the areas on this body where you feel the described sensations. Use the symbols below to indicate different sensations. Mark areas to which you feel the pain radiating. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /



Symptoms are: (Check one)
- o Worse in morning
- o Worse in evening
- o Consistent
- o Come and go

How did the symptoms develop?: (Check one)
- o Job-related injury
- o Auto accident
- o Accident
- o Illness
- o Unknown
- o Gradual Onset

How long have the symptoms persisted for? _____
Have you experienced these symptoms previously? __no __yes

Please check the following activities that **aggravate** your condition:
- o Bending
- o Reaching
- o Coughing
- o Sitting
- o Lying down
- o Turning your head
- o Lifting
- o Sneezing
- o Walking
- o Standing
- o Straining at stool (defication)

Please check the following activities that **relieve** your condition:
- o Bending
- o Sitting
- o Lifting
- o Standing
- o Lying down
- o Turning head
- o Reaching
- o Walking
- o Rest

Social History
Are you a smoker or have a history of smoking? _No _Yes. If Yes, _____ packs/day for ___ of years?
Please list any allergies:_____
Please list any medications and/or supplements you are currently taking: _____
Is there any chance you are pregnant?____ Please list date of last menstrual period_____

Medical/Family History

The following is a list of conditions that can be essential in diagnosing your problem. Please make a check under the column with **Now** if you have had any of these conditions *within the past 12 months*; or **Past** column if you *have ever had* these conditions in the past. Please also check if an *immediate family member* has experienced any of the following conditoins under the column **Family**.

	Now	**Past**	**Family**		**Now**	**Past**	**Family**
Headaches____ Frequency	____	____	____	Loss of Balance	____	____	____
Neck Pain	____	____	____	Fainting	____	____	____
Stiff Neck	____	____	____	Loss of Smell	____	____	____
Sleeping Problems	____	____	____	Loss of Taste	____	____	____
Back Pain	____	____	____	Diarrhea	____	____	____
Nervousness	____	____	____	Feet Cold	____	____	____
Tension	____	____	____	Hands Cold	____	____	____
Irritability	____	____	____	Arthritis	____	____	____
Chest Pains	____	____	____	Muscle Spasms	____	____	____
Dizziness	____	____	____	Frequent Colds	____	____	____
Shoulder/Neck/Arm Pain	____	____	____	Stomach Upset	____	____	____
Pins & Needles in Arms	____	____	____	Constipation	____	____	____
Pins & Needles in Legs	____	____	____	Cold Sweats	____	____	____
Numbness in Fingers	____	____	____	Fever	____	____	____
Numbness in Toes	____	____	____	Sinus Problems	____	____	____
High Blood Pressure	____	____	____	Diabetes	____	____	____
Difficulty Urinating	____	____	____	Hemorrhoids	____	____	____
Allergies	____	____	____	Leg Cramps	____	____	____
Weakness in Arms	____	____	____	Colitis	____	____	____
Weakness in Legs	____	____	____	Gall Bladder	____	____	____
Shortness of Breath	____	____	____	Indigestion	____	____	____
Fatigue	____	____	____	Belching	____	____	____
Depression	____	____	____	Vomiting	____	____	____
Lights Bother Eye	____	____	____	Shoulder Pain	____	____	____
Loss of Memory	____	____	____	Swelling Joints	____	____	____
Ears Ring	____	____	____	Knee Pain	____	____	____
Face Flushed	____	____	____	Hayfever	____	____	____
Buzzing in Ears	____	____	____	Menstrual Difficulties	____	____	____

Please list any surgeries you have had:

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

Have you ever been diagnosed with a **significant disease or illness?** ___Yes ___No. If yes, please describe:

_____

Have you ever had a **major injury that required hospitalization?** __Yes __No. If yes, please explain:

_____

Primary Care Physician:

Name_____ Phone number _____

Date of last physical exam: _____

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Absolute Healthcare Advanced Chiropractic.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been informed of the Notice of Privacy Practices of Chiropractor and understand that I have the right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is posted in the waiting room at 1973 SW Savage Blvd., #111. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority