Date_____

Home Phone_____
Work Phone_____
Cell Phone_____

Patient Information

Name_____ SSN_____
First Last Middle Initial

Address_____ City_____ State_____ Zip_____

Sex (circle one) Male Female Age____ Birthdate_____ Marital status (circle one) Single Married Widowed Separated Divorced

Employer_____ Occupation_____

Email Address _____

In case of emergency, who should be notified?_____ Phone_____

Primary Insurance

Insured name_____ SSN_____
First Last MI

Relation to patient (circle one) Self Spouse Child Other Birthdate_____ Phone_____

Address (If different from patient's)_____ City_____ State_____ Zip_____

Insured's employer_____

Insurance Company_____

ID#_____ Group#_____

Additional Insurance

Is patient covered by additional insurance? (circle one) Yes No

Insured name_____ SSN_____
First Last MI

Relation to patient (circle one) Self Spouse Child Other Birthdate_____ Phone_____

Address (If different from patient's)_____ City_____ State_____ Zip_____

Insured's employer_____

Insurance Company_____

ID#_____ Group#_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____ _____ _____
Responsible Party Relationship Date

Reason for Visit

Major complaint_____

Other complaints_____

Is this the result of an accident?(circle one) Yes No

If so, what kind of accident?(circle one) Auto Work Other Date of accident_____

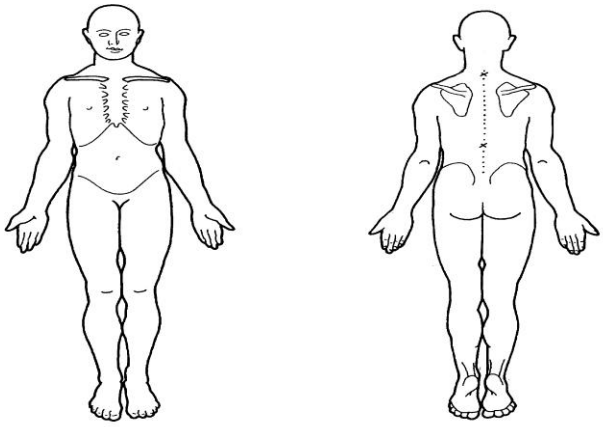
Explain what happened_____

_____

_____

Describe the pain. (circle one) Aching Burning Throbbing Stabbing Numbness Pins & Needles Other

Mark the location of the pain.



How long have you been having this pain?_____

Is the condition getting worse?_____

Is it constant? (circle one) Yes No Comes and goes? (circle one) Yes No

Is this condition interfering with your (circle one) Work? Sleep? Daily routine?

If so, please explain_____

Have you had this or similar conditions in the past? (circle one) Yes No

When was the last time?_____

Have you been treated by a Medical Physician for this condition? (circle one) Yes No

If so, who?_____ Were medications prescribed? (circle one) Yes No

Please list_____

Have you been seen by a Chiropractor before?(circle one) Yes No

If so, who?_____ When?_____

For what condition(s)?_____

_____

Medical History

Check any symptoms you currently have or have had in the past year.

___ Headaches	___ Buzzing in ears	___ Irritability	___ Diarrhea
___ Dizziness	___ Ringing in ears	___ Trouble sleeping	___ Urinary problem
___ Pins & Needles in arms	___ Fatigue	___ Tension	___ Mood Swings
___ Pins & Needles in legs	___ Depression	___ Fever	___ Loss of smell
___ Numbness in fingers	___ Constipation	___ Cold sweats	___ Loss of taste
___ Numbness in toes	___ Menstrual pain	___ Fainting	___ Back pain
___ Cold hands	___ Ulcers	___ Blurred/double vision	___ Neck pain
___ Cold feet	___ Hot flashes	___ Stomach upset	___ Stiff neck

Check any conditions you currently have or have had in the past year.

___ Heart attack/Stroke	___ HIV+/AIDS	___ High/Low blood pressure	___ Kidney problems
___ Heart surgery/Pacemaker	___ Hepatitis	___ Psychiatric problems	___ Sinus problems
___ Heart murmur	___ Shingles	___ Severe/Frequent headaches	___ Difficulty breathing
___ Congenital heart defect	___ Cancer	___ Kidney problems	___ Artificial joint/bones
___ Mitral Valve Prolapse	___ Frequent Neck Pain	___ Ulcers/Colitis	___ Asthma
___ Artificial valves	___ Emphysema	___ Fainting/Seizures	___ Chemotherapy
___ Alcohol/Drug abuse	___ Glaucoma	___ Diabetes	___ Arthritis
___ Venereal disease	___ Anemia	___ Lower back problems	

Please list any other serious medical conditions or diseases you currently have or have had in the last year

_____

_____

List any medications you are currently taking_____

_____

Please list anything that you may be allergic to_____

List previous surgeries/treatments with dates_____

List any past serious accidents with dates_____

Do you smoke? (circle one) Yes No How much?_____ How long?_____

For Women:

Are you pregnant? Yes No How far along?_____ Are you nursing? Yes No Number of children_____

I certify that all of the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient signature Date

_____ _____

Parent/Guardian Signature Date

Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

Check if your blood relatives had any of the following:

	Disease	Relationship to You
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Health Habits

Check which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Occupation: _____

Check if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? (circle one) Yes No
If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications (if any)

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

Health and Medical Information Release Form

I, _____, give permission to the staff, associates and employees of Circle City Chiropractic t share private and medical information with my medical doctors as well as his/her staff, employees and associates. Also, my medical doctors, as well as their staff, employees and associates have my permission to share personal and medical information with the staff, associates and employees of Circle City Chiropractic.

Signature:_____

Date:_____

Medical Doctor Information

Name of Doctor:_____

Address: _____

City, State, Zip: _____

Phone: _____

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____

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

In the course of your care as a patient at Circle City Chiropractic, we may use or disclose personal and/or health related

information about you in the following ways:

- **Your personal health information, inclusive of your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment,**
- **Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer if they are or may be responsible for the payment of your services.**
- **Your name, address, phone number, and your healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.**

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing chiropractic care services to you based on the orders of another chiropractic 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, or
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than that outlined above, will be made only upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing of your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Tom Nottingham.

If you would like further information about our privacy policies and practices please contact Dr. Tom Nottingham.

This office uses and "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements can be made for you.

This notice is effective as of_____. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please)	Signature	Date

If you are a minor or if another party is representing you, a signature is required by that person.

Personal Representative (Printed)	**Personal Representative Signature**	**Date**

Description of the authority to act on behalf of the patient.