

Confidential Patient Health Record

Today's Date: ____/____/2010

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Yellow pages Drove by Hospital Insurance Plan Letter in mail

Personal Information

Title: Mr. Ms. Mrs. Dr. Rev. Miss Prof. **Suffix:** Jr./Sr./III _____
Last: _____ **First:** _____ **Middle:** _____
Birth Date: ____/____/____ **Age:** ____ **Sex:** Male / Female **Social Security #:** _____ - _____ - _____
Primary Language: English French German Spanish other: _____
Driver's License #: _____ **State:** _____
Marital Status: Single Married Widowed Divorced Separated
Address: _____ **Apt #** _____
City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____
Home Phone: (____) _____ - _____ ext ____ **Work Phone:** (____) _____ - _____ ext ____
Cell Phone: (____) _____ - _____ **Provider:** AT&T Verizon Cricket
Fax #: (____) _____ - _____ **Sprint T-Mobile Alltel Other:** _____
Email Address: _____ **Spouses Name:** _____

Emergency Contact or Guardian (if child)

Title: Miss Mrs. Ms. Master Mr. Dr. Prof. Rev. other: _____
Last: _____ **First:** _____ **Middle:** _____ **Suffix:** _____
Address: _____ **Apt #** _____
City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____
Relationship: Spouse Relative/Specify _____ Friend Other _____
Email Address: _____ **Birth Date:** ____/____/____ **Social Security #:** _____
Work Phone: (____) _____ - _____ ext ____ **Cell Phone:** (____) _____ - _____

Insurance Information:

Who Is Responsible For Your Bill? YOU and... (mark appropriate box(es)) Myself ONLY
 Spouse Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____
Personal Health Insurance Carrier: _____ **Health ID Card #:** _____
Policy Holder's Name: _____ **Group #:** _____
Policy Holder's Social Security #: _____ - _____ - _____ **Primary Care Physician:** _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No **Date:** ____/____/____ **Time:** _____ am/pm
Carrier: _____ **Policy #** _____ **Claim #:** _____
Adjuster: _____ **Adjuster's Phone #:** (____) _____ - _____

Employment Information or Guardian's Employment

Business Name: _____
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ Country: _____ County: _____
Phone: (_____) _____ - _____ Fax #: (_____) _____ - _____
Employer's Email Address: _____
Occupation/Job Title: _____ Job Description _____

Current Health Condition

Unwanted Condition (Why you are here today?): _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? ____/____/____

Has it ever occurred before? Yes No. When? _____

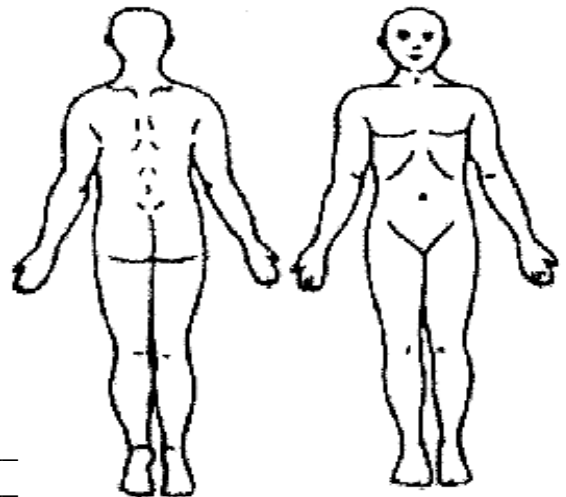
Is the Condition: Auto Related Job Related Home Injury
 Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?



Family Physician Information:

Who is your Family Physician? _____ Location: _____

Telephone # _____ Date of last visit: _____

Reason for visit: _____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: I DENY having or have had any of the symptoms or problems listed below.

- | | | | |
|---|----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> chills | <input type="checkbox"/> fatigue | <input type="checkbox"/> night sweats | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> daytime drowsiness | <input type="checkbox"/> fever | <input type="checkbox"/> weight gain | |

Eyes/Vision: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> blindness | <input type="checkbox"/> change in vision | <input type="checkbox"/> field cuts | <input type="checkbox"/> photophobia |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> double vision | <input type="checkbox"/> glaucoma | <input type="checkbox"/> tearing |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> eye pain | <input type="checkbox"/> itching | <input type="checkbox"/> wear glasses/contacts |

Ears, Nose and Throat: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|--|--|---|--|---------------------------------------|
| <input type="checkbox"/> bleeding | <input type="checkbox"/> ear drainage | <input type="checkbox"/> hearing loss | <input type="checkbox"/> nosebleeds | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> dentures | <input type="checkbox"/> ear pain | <input type="checkbox"/> history of head injury | <input type="checkbox"/> postnasal drip | <input type="checkbox"/> tinnitus |
| <input type="checkbox"/> difficulty Swallowing | <input type="checkbox"/> fainting | <input type="checkbox"/> hoarseness | <input type="checkbox"/> rhinorrhea (runny nose) | (ringing in ears) |
| <input type="checkbox"/> discharge | <input type="checkbox"/> frequent sore throats | <input type="checkbox"/> loss of sense of smell | <input type="checkbox"/> sinus infections | <input type="checkbox"/> TMJ problems |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> headaches | <input type="checkbox"/> nasal congestion | <input type="checkbox"/> snoring | |

Respiration: I DENY having any of the symptoms or problems listed below.

- | | | |
|---------------------------------|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> coughing up blood | <input type="checkbox"/> sputum production |
| <input type="checkbox"/> cough | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing |

Cardiovascular: I DENY having any of the symptoms or problems listed below.

- | | | |
|--|--|--|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> shortness of breath with exertion or exercise |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low blood pressure | |
| <input type="checkbox"/> claudication (leg pain/ache) | <input type="checkbox"/> orthopnea (difficulty breathing lying down) | <input type="checkbox"/> swelling of legs |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> palpitations | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath) | <input type="checkbox"/> varicose veins |

Gastrointestinal: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool caliber | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice | <input type="checkbox"/> abnormal stool color | |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn | <input type="checkbox"/> nausea | <input type="checkbox"/> abnormal stool consistency | |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | |

Female: I DENY having any of the symptoms/problems and/or using any of the items listed below.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> birth control | <input type="checkbox"/> cramps | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> vaginal bleeding |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> frequent urination | <input type="checkbox"/> pregnancy | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> burning urination | <input type="checkbox"/> hormone therapy | <input type="checkbox"/> urine retention | |

Male: I DENY having any of the symptoms or problems listed below.

- | | | |
|---|---|--|
| <input type="checkbox"/> burning urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/ dribbling | <input type="checkbox"/> urine retention |

Endocrine: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> cold intolerance | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> goiter | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> hair loss | <input type="checkbox"/> voice changes |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> abnormal frequency of urination | <input type="checkbox"/> heat intolerance | |

Skin: I DENY having any of the symptoms or problems listed below.

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss | <input type="checkbox"/> itching | <input type="checkbox"/> skin lesions / ulcers |
| <input type="checkbox"/> changes in skin color | <input type="checkbox"/> hives | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities |
| <input type="checkbox"/> hair growth | <input type="checkbox"/> history of skin disorders | <input type="checkbox"/> rash | |

Nervous System: I DENY having any of the symptoms or problems listed below.

- dizziness limb weakness numbness slurred speech tremor
- facial weakness loss of consciousness seizures stress unsteadiness of gait/
- headache loss of memory sleep disturbance strokes loss of balance

Psychologic: I DENY having any of the symptoms or problems listed below.

- anhedonia behavioral change convulsions memory loss
- anxiety bi-polar disorder depression mood change
- loss or change in appetite confusion insomnia

Allergy: I DENY having any of the symptoms or problems listed below.

- anaphalaxis itching chronic nasal congestion sneezing
- food intolerance acute nasal congestion rash

Hematologic: I DENY having any of the symptoms or problems listed below.

- anemia blood clotting bruising easily lymph node swelling
- bleeding blood transfusion fatigue

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:
 I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____
 Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No
 Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____
 Were you satisfied with your care? Yes No. Why? _____
 Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other _____
 For how long? _____ Were they prescribed by a doctor? Yes or No.

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you been taking this?

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- ADD chicken pox headaches scoliosis
- atopic dermatitis (eczema) crohn's/colitis hepatitis seizure disorder
- allergies/hayfever depression HIV sickle cell anemia
- anemia diabetes measles spina bifida
- asthma ear infections mumps other:
- bedwetting fetal drug exposure psoriasis
- cerebral palsy food allergies (list below) rash

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

Adult Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> alzheimers | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoid) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | |

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental surgery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsilectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | |

Females ONLY: Ob/Gyn Mark all that apply below.

If you have been pregnant in the past, please fill in the appropriate information below.

_____ Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____ Number of C-sections	_____ Number of vaginal deliveries
_____ Number of miscarriages	_____ Number of terminated pregnancies
I... <input type="checkbox"/> am currently pregnant	<input type="checkbox"/> am NOT currently pregnant

Menstrual History.

I... <input type="checkbox"/> currently have menses.	<input type="checkbox"/> currently DO NOT have menses.
My menses... <input type="checkbox"/> are regular.	<input type="checkbox"/> are NOT regular.
_____ Age of first menses	_____ Age when metaphase began
Date of last menses: _____ / _____ / _____	

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> other: |

Immunizations: Please list the date(s) next to the immunization, if known.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> adenovirus | <input type="checkbox"/> hepatitis C | <input type="checkbox"/> pertussis | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> anthrax | <input type="checkbox"/> influenza | <input type="checkbox"/> pneumococcal | <input type="checkbox"/> tularemia |
| <input type="checkbox"/> botulism | <input type="checkbox"/> IPV (polio) | <input type="checkbox"/> pneumovax | <input type="checkbox"/> typhoid |
| <input type="checkbox"/> diphtheria | <input type="checkbox"/> Japanese encephalitis | <input type="checkbox"/> PPD (mantoux test- TB) | <input type="checkbox"/> varivax (chicken pox) |
| <input type="checkbox"/> DTaP (diphtheria, tetanus, pertussis) | <input type="checkbox"/> lyme disease | <input type="checkbox"/> rabies | <input type="checkbox"/> whooping cough (pertussis) |
| <input type="checkbox"/> flu | <input type="checkbox"/> measles | <input type="checkbox"/> rubella | <input type="checkbox"/> yellow fever |
| <input type="checkbox"/> hepatitis A | <input type="checkbox"/> meningococcal | <input type="checkbox"/> rotavirus | <input type="checkbox"/> haemophilus B |
| <input type="checkbox"/> hepatitis B | <input type="checkbox"/> MMR | <input type="checkbox"/> smallpox | <input type="checkbox"/> other: |
| | <input type="checkbox"/> mumps | <input type="checkbox"/> tetanus | |

X-RAY CONSENT FORM

I, _____, certify that I am not presently pregnant, and assume full responsibility for any complications that may arise from receiving x-ray studies. I fully understand the complications and risks involved by receiving x-rays to me and to an unborn child. I hereby release this facility and any owner or representative from any responsibility.

Signed _____ Date: _____

PATIENT AUTHORIZATION
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I, _____, hereby authorize DeMaine Chiropractic & Wellness Center P.A. (the "Practice") to use and/or disclose to Health Insurance Agencies, Attorney's, Business Associates, and DeMaine Chiropractic & Wellness Center, P.A., Employees, the following specific protected health information: Personal Health Information, The Care and Treatment Receiving or Received, and Relevant Personal Data. I understand that this authorization is valid until ___/___/___ or until 2 years from the date of signature.

2. I understand that the purpose or use of the disclosure I am granting is for the purpose of: Treatment, Authorization, Payment, and/or Health Care Operations

3. I expressly acknowledge that this authorization is voluntary.

4. The following is/are other criteria or limitations that I make regarding this authorization:

5. I understand that the office _____ will X will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. (excluding payment for a claim submission)

6. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

7. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

8. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.

9. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

10. This form was completely filled in before I signed it. I certify that all my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

11. This authorization is valid as of ___/___/___, the date I have signed below. You can obtain a copy of DeMaine Chiropractic & Wellness Center, P.A. HIPPA Privacy Policy and Notice upon request.

Name of Individual (Printed)

Signature of individual

Signature of Legal Representative

Relationship

