360 Chiropractic WELLNESS

PATIENT CONTACT INFORMATION

FIRST NAME | MIDDLE | LAST | SUFFIX | TODAY'S DATE

ADDRESS | CITY | STATE | ZIP CODE

( ) HOME | ( ) CELL | EMAIL ADDRESS

BIRTHDATE (MM/DD/YYYY) | ( ) AGE | PATIENT SOCIAL SECURITY NUMBER | DRIVER'S LICENSE NUMBER

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced

Women: Are you Pregnant? _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Full-time Student ☐ Part-time Student

Who may we thank for referring you to our office?_____

EMERGENCY CONTACT

_____
NAME: FIRST LAST

_____(_____)_____
RELATIONSHIP PHONE

INSURANCE INFORMATION

_____
NAME OF PRIMARY INSURANCE

_____
NAME OF SECONDARY INSURANCE (IF ANY)

ADDITIONAL CONTACTS-EMPLOYER INFORMATION

EMPLOYER NAME | OCCUPATION

ADDRESS | PHONE

SPOUSE INFORMATION

SPOUSE NAME: FIRST | LAST | ( ) CELL PHONE

EMPLOYER NAME | OCCUPATION | ( ) WORK PHONE

HISTORY OF PRESENT CONDITION

CHIEF COMPLAINT: Purpose of this appointment (Briefly describe)**:** _____

Date symptoms appeared or accident happened? _____

Condition is due to: ☐ Work injury ☐ Auto Accident ☐ Other _____

How did your pain begin? ☐ No Apparent Reason ☐ Gradual ☐ Bending ☐ Lifting ☐ Fall ☐ Injury ☐ Repetitive

☐ Other, describe: _____

Have you seen a chiropractor before? _____ **If so, how long ago?** _____ **What Doctor did you see?**_____

Have you had the same or similar condition? ☐ No ☐ Yes

Have you seen another Health Care Professional for it? _____**If so, about how long ago?** _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

Broken or fractured bones? Explain:_____

_____ Excessive Bleeding
_____ High/Low Blood Pressure
_____ Osteoarthritis
_____ Epilepsy
_____ Pace Maker
_____ Circulatory Problems
_____ A Congenital Disease
_____ Strokes
_____ Cancer
_____ Ruptures
_____ Coughing Blood
_____ Eating Disorder
_____ Rheumatoid Arthritis
_____ Ulcers
_____ Alcoholism
_____ Drug Addiction
_____ HIV Positive
_____ Gall Bladder
_____ Depression
_____ Seizures/Convulsions

Do you have a history of stroke or hypertension? YES NO If Yes, Explain: _____

List any illnesses, injuries, falls, auto accidents or surgeries? (Women, please include information about childbirth-including dates.):

_____

What Medications or Drugs are you taking? _____

_____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

SOCIAL HISTORY

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use tobacco products? _____ Do you smoke? _____ If so, how many packs per day? _____

Do you take vitamin supplements? _____ If so, please list: _____

Do you excersise? _____ If yes, what is the frequency and type of exercise? _____

What are you hobbies? _____

What percentage of time during the day (at home or at your job) do you spend:

Lifting _____% Sitting _____% Bending _____% Working at the computer _____%

FAMILY HISTORY

FATHER (Check one):

Living _____ Deceased _____ If still Living/Current Age _____

Cause of death and age of death (if deceased): _____

_____

MOTHER (Check one):

Living _____ Deceased _____ If still Living/Current Age _____

Cause of death and age of death (if deceased): _____

_____

FAMILY DISEASES

(Check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother)

Stroke: _____ F M S B
Arthritis: _____ F M S B
Cancer: _____ F M S B
Asthma: _____ F M S B
Heart Disease: _____ F M S B
Lung Disease: _____ F M S B
Kidney Disease: _____ F M S B

Other: _____

PATIENT HISTORY

Childhood Diseases: Measles _____ Mumps _____ Chiken Pox _____ Others _____

Adult Illnesses or Conditions: _____

Have you ever had, or do you now have, any of the following symptoms which are a significant distress to you?

C = CURRENTLY P= PREVIOUS

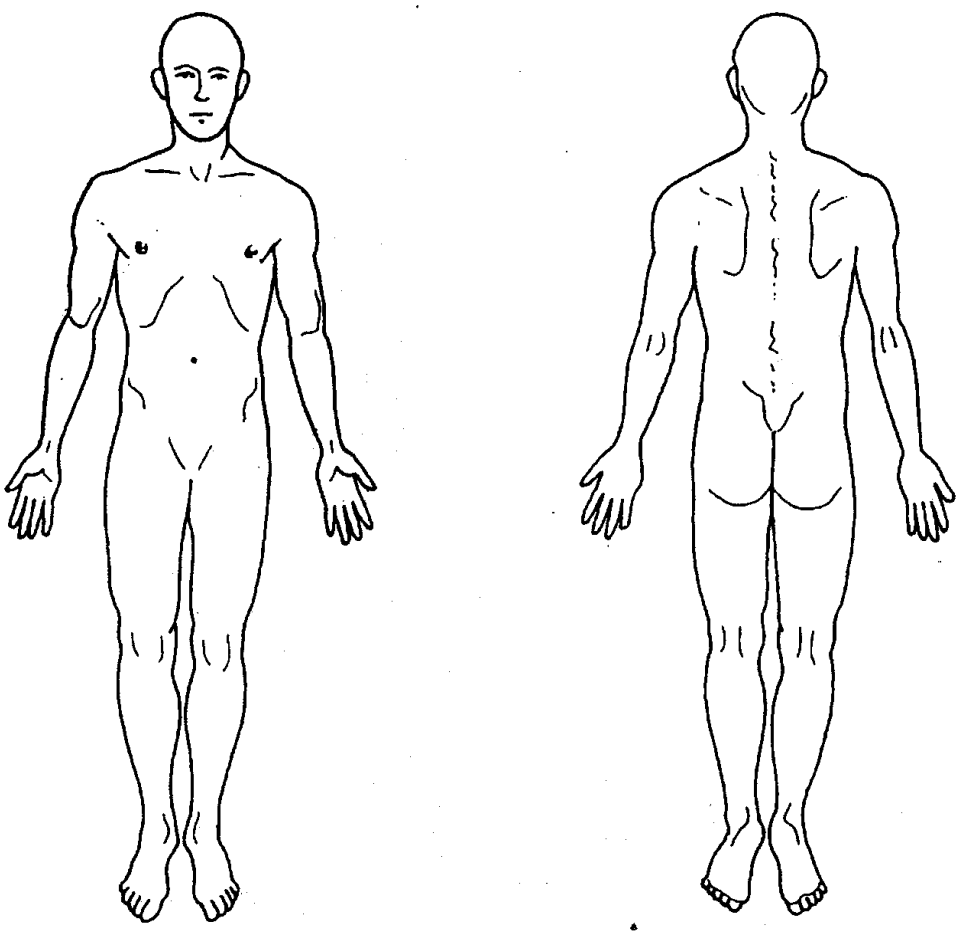
Headaches: Yes/No_____ **Frequency:** _____

Shoulder/Neck/Arm Pain	C	P	Sleeping Problems	C	P	Unusual Bowel	C	P	Back Pain	C	P
Weakness in Extremities	C	P	Lights Bother Eyes	C	P	Loss of Taste	C	P	Stiff Neck	C	P
Chest Pains/Tightness	C	P	Numbness in Toes	C	P	Nervousness	C	P	Irritability	C	P
Indigestion Problems	C	P	Difficulty Urinating	C	P	Loss of Smell	C	P	Diabetes	C	P
Numbness in Fingers	C	P	Weight Loss/Gain	C	P	Hands Cold	C	P	Tension	C	P
Menstrual Difficulties	C	P	Loss of Balance	C	P	Depression	C	P	Fatigue	C	P
High Blood Pressure	C	P	Loss of Memory	C	P	Feet Cold	C	P	Fainting	C	P
Buzzing in the Ears	C	P	Muscle Spasms	C	P	Ears Ring	C	P	Patterns	C	P
Joint Pain/Swelling	C	P	Frequent Colds	C	P	Neck Pain	C	P	Arthiritis	C	P
Breathing Problems	C	P	Sinus Problems	C	P	Dizziness	C	P	Fever	C	P

PAIN DRAWING

TELL US WHERE YOU HURT.

Mark the areas on your body where you feel your pain with an **X** symbol. Include **ALL** affected areas. Describe the type of pain you are feeling as an Ache, Numbness, Pins & Needles, Burning, Stabbing, or Throbbing.



PATIENT HEALTH INFORMATION CONSENT FORM (HOW WE USE YOUR INFORMATION)

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 will begin any health care operations we must require you to read and sign this consent form stating that 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 HIPAA NOTICE that is available to you at the front desk before signing this consent. (1) The patient understands and agrees to allow 360 chiropractic Wellness 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 our 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 that our 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 in this office. (4) The patient may provide a written request to revoke consent at any time during care. This would not affect 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 have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that 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, our office 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 SIGNATURE: _____ DATE: _____

INFORMED COSENT FOR CHIROPRACTIC CARE (PERMISSION TO TREAT)

A patient, in coming to our office, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor. The Doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime. I understand that if I am accepted as a patient by a physician at 360 Chiropractic Wellness, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

PATIENT SIGNATURE: _____ DATE: _____

MISSED APPOINTMENT POLICY (DO UNTO OTHERS)

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding missed and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least **24 hours notice** in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time. Since our office does not charge for missed or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

PATIENT SIGNATURE: _____ DATE: _____

PREGNANCY WAIVER (I'M NOT PREGNANT!)

I hereby acknowledge that Dr. Jared L Hanson of 360 Chiropractic Wellness has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

PATIENT SIGNATURE: _____ DATE: _____