Allen Chiropractic Wellness Center
1018 S. Westwood Blvd., Ste. 5
Poplar Bluff, MO 63901
Phone: 573-778-0500
Fax: 573-778-0160

CONFIDENTIAL HEALTH INFORMATION

All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

1 Patient Information

Today's Date_____ SSN# _____ Patient Account # _____

Patient Name (Last)_____

(First)_____

Address_____

City_____ State _____ Zip_____

Email_____

Birth Date _____ Age _____ Male Female

___ Single ___ Married ___ Separated
___ Divorced ___ Widowed ___ Minor

Employer _____

Occupation _____

SPOUSE

Spouse's Name _____

Spouse's Employer _____

How did you hear about our office?
_____ Internet Search _____ Phone Book _____ Sign

Referred by: _____

Other source: _____

2 Phone Numbers

Home _____

Cell _____

Work _____

Best Number to reach you is:

_____

IN CASE OF EMERGENCY, CONTACT

Name _____Relationship_____

Cell _____*Home* _____

3 Accident Information

Is condition due to an accident? ___Yes
___No

Type of Accident __Auto __Work __Home
__Other

Accident Date: _____

To Whom have you made a report of your accident?
___Auto Insurance ___Employer
___ Workman's Comp ___*Other*

4 Patient Condition

Reason for visit _____

When did your symptoms appear? _____
Is condition getting progressively worse? __ Yes __ No __ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: __Sharp __Dull __Throbbing __Numbness __Aching __Shooting __Burning __Tingling __Cramps __Stiffness __Swelling __Other

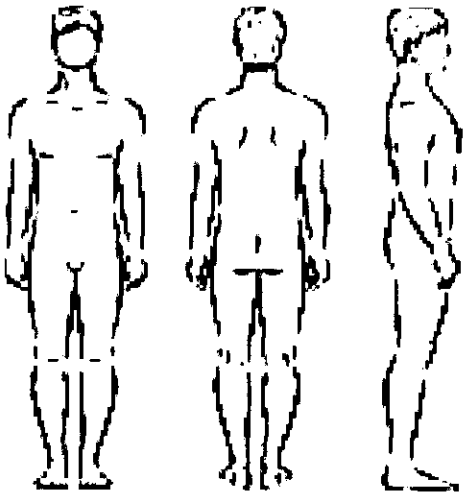
How often do you have this pain? _____

Is it constant? Or does it come and go? _____

Does it interfere with your: __Work __Daily routine __ Sleep __Recreation

Activities that are painful to perform: __Sitting __Standing __Walking __ Bending __Lying Down

Mark an X on the picture where you continue to have pain, numbness or tingling.



5 Health History

What treatment have you already received for your condition?

___Medications ___Surgery ___Physical Therapy ___Chiropractic ___None

___Other _____

Name and City/St of other doctors who have treated you for your condition_____

Date of last: Physcial Exam_____ Spinal Exam_____ Spinal X-ray _____

Chest X-ray _____ MRI, CT Scan, Bone Scan _____ Lab Work _____

Name of Facility where procedure was done _____

WOMEN: Are you pregnant? ___Yes ___ No Due Date: _____

Date of your last period: _____

Please list any vitamins/supplements that you are taking: _____

_____

_____

_____

GENERAL

1) ____ Fever
2) ____ Chills
3) ____ Night Sweats
4) ____ Loss of Sleep
5) ____ Fatigue
6) ____ Nervousness
7) ____ Weight Loss or Gain
8) ____ Allergies
9) ____ Bleeding Problem
10) ____ Anemia
11) ____ Diabetes
12) ____ Cancer
13) ____ Thyroid Disease/Goiter
14) ____ Alcoholism
15) ____ Drug Abuse

EYE EAR NOSE THROAT

16) ____ Poor Vision
17) ____ Pain in Eye(s)
18) ____ Deafness/Difficulty Hearing
19) ____ Nosebleeds
20) ____ Nose Problems
21) ____ Sinus Trouble
22) ____ Dental Problems
23) ____ Hoarseness
24) ____ Tonsillectomy

GASTROINTESTINAL

25) ____ Poor Appetite
26) ____ Poor Digestion
27) ____ Difficulty Swallowing
28) ____ Belching or Gas
29) ____ Frequent Nausea
30) ____ Vomiting
31) ____ Vomiting Blood
32) ____ Pain over Abdomen
33) ____ Ulcer
34) ____ Black or Bloody Stools
35) ____ Liver Problems
36) ____ Gall Bladder Problems
37) ____ *Jaundice*
38) ____ Hernia
39) ____ Diarrhea
40) ____ Constipation
41) ____ Hemorrhoids
42) ____ Appendicitis

MEN ONLY

43) ____ Testicular Swelling/Pain
44) ____ Prostate Problems

RESPIRATORY

45) ____ Difficulty Breathing
46) ____ Chronic Cough
47) ____ Spitting Phlegm
48) ____ Spitting Blood
49) ____ Wheezing/Asthma
50) ____ Pneumonia
51) ____ Tuberculosis

CARDIOVASCULAR

52) ____ Irregular Heartbeat
53) ____ High Blood Pressure
54) ____ Pain over Heart
55) ____ Previous Heart Trouble
56) ____ Ankle Swelling
57) ____ Varicose Veins
58) ____ Rheumatic Fever
59) ____ Stroke

GENITOURINARY

60) ____ Frequent Urination
61) ____ Painful Urination
62) ____ Blood in Urine
63) ____ Kidney Disease
64) ____ Urinary Infection
65) ____ Inability to Control Urination
66) ____ Difficulty Starting Urine Flow
67) ____ Get Up ____ Times per Night to Urinate
68) ____ Breast Lump or Pain
69) ____ *Venereal Infection*
70) ____ Sexual Difficulties

SKIN

71) ____ Itching
72) ____ Bruising Easily
73) ____ Change in Mole(s)
74) ____ Skin Cancer

WOMEN ONLY

75) ____ Painful Periods
76) ____ Excessive Flow
77) ____ Irregular Cycles
78) ____ Vaginal Burning/Itching
79) ____ Hot Flashes

80) _____
Date Last Period Began

81) _____
Date of Last PAP Test

NEUROLOGIC

82) ____ Weakness
83) ____ Twitching
84) ____ Tremors
85) ____ Headache
86) ____ Fainting
87) ____ Dizziness
88) ____ Convulsions
89) ____ Epilepsy
90) ____ Numbness/Tingling
91) ____ Arm/Leg Pain (125)
92) ____ Mental Disorder

MUSCULOSKELETAL

93) ____ Neck Stiffness/Pain
94) ____ Pain Between Shoulders
95) ____ Low Back Pain
96) ____ Swollen Joints
97) ____ Painful Joints (CC)
98) ____ Muscle Aches/Soreness
99) ____ Spinal Curvature
100) ____ Arthritis

HABITS

101) ____ Smoking ____ Packs/Day
102) ____ Drinking
103) ____ Recreational Drug Use

EXERCISE

104) ____ None
105) ____ 1-2 Times/Week
106) ____ 3-5 Times/Week
107) ____ 6-7 Times/Week

FAMILY HISTORY

Include information on brothers, sisters, parents and grandparents. DO NOT INCLUDE YOURSELF.

108) ____ Diabetes
109) ____ Thyroid Disease/Goiter
110) ____ Tuberculosis
111) ____ Kidney Disease
112) ____ High Blood Pressure
113) ____ Heart Disease
114) ____ Cancer
115) ____ Muscle, Bone or Nerve Disease

New Patient Case History

Name: _____

List any **Allergies**:

· Animals · Aspirin · Bees · Chocolate · Dairy · Dust · Eggs· Latex · Molds · Penicillin · Ragweed/Pollen

· Rubber · Seasonal Allergies · Shellfish · Soaps · Wheat · X-Ray Dye · Other: _____

List any **Surgeries**:

· Back · Brain · Elbow · Foot ·Heart · Hip · Knee · Neck · Neurological · Shoulder · Wrist · Other: _____

List **ALL Past Medical History** conditions:

· Ankle Pain · Arm Pain · Arthritis · Asthma · Back Pain · Broken Bones · Cancer · Chest Pain · Depression

· Diabetes ·Disc Bulge · Dizziness · Elbow Pain · Epilepsy · Eye/Vision Problems · Fainting · Fatigue ·Fibromyalgia

· Foot Pain · Genetic Spinal Condition · Hand Pain · Headaches · Hearing Problems · Hepatitis · High Blood Pressure

· Hip Pain · HIV ·Irritable Bowel Syndrome · Jaw Pain · Joint Stiffness ·Kidney Issues · Knee Pain · Leg Pain ·

· Low Blood Pressure · Menstrual Problems · Mid-Back Pain · Minor Heart Problem · Multiple Sclerosis · Neck Pain

·Neurological Problems · Pacemaker · Parkinson's · Polio · Prostate Problems ·Scoliosis · Shoulder Pain · Significant Weight Change ·Skin Issues · Spinal Cord Injury · Sprain/Strain ·Stroke/Heart Attack ·TMJ ·Thyroid Issues ·Ulcer/s

Other: _____

List Type and Name of **Medications** you are taking:

· Anxiety · Muscle Relaxers · Pain Killers · Insulin · Birth control · Cardio-vascular · Allergy · Seizure ·Thyroid

· Blood Pressure ·Cholesterol · Other: _____

List your **Family History**:

· Arthritis · Asthma · Back Pain · Cancer · Depression · Diabetes · Epilepsy · Genetic Spinal Condition

· High Blood Pressure · Heart Problems · Multiple Sclerosis · Neurological Problems · Parkinson's · Polio

· Prostate Problems · Stroke/Heart Attack · Other: _____

Have you had any auto or other accidents? · No ·Yes

Describe: _____

Date of last physical examination: _____

Do you smoke? · No ·Yes

Do you drink Water? ·No ·Yes - How much per day? _____

Do you drink alcohol? · No ·Yes - how many per day? _____

Do you drink caffeine? · No ·Yes - how many per day? _____

Do you exercise? · No ·Yes (what forms and how often): _____

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AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine and/or other recommended therapies, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

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Authorization to Disclose Protected Health Information

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives Allen Chiropractic Wellness Center permission to use/obtain your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to revocation of this consent are covered by this consent.

Patient Signature:_____ Date:_____

Records requested:

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies. These changes in our office policy and practice may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies will be applied to all protected health information we maintain.

Doctor/Staff Signature:_____ Date:_____