ELLIOTT CHIROPRACTIC SINCE 1910

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Please complete and return to our patient facilitator at the front desk

New Patient Information

Title you prefer: Mr. Mrs. Miss Ms. Dr. Pastor Marital Status: Married Single Divorced Widowed

Patient Name: ____
Legal First Middle Last Nickname

Address: ____
Street City State Zip

Home Phone (______) __________________________ Work Phone (______) ___________________________

Cell Phone (______) ___________________________ E-Mail: ____

Which phone number do you prefer we use to contact you? Home Cell Work

Sex: Male Female Social Security #: ______-_____-______ Birth date: _____/_____/_____ Age: _____

Employer: _______________________________________ Occupation: ________________________________

Who may we thank for referring you? ____

Spouse Information

Spouse's Name: ____
Legal First Middle Last Nickname

Social Security #: ______-_____-______ Birth Date: _____/_____/_____ Age: _______

Employer: _______________________________________ Occupation: ________________________________

Cell Phone (______) __________________________ Work Phone (______) ___________________________

Parent Information (If patient is 18 or under)

Parent Name: ____
Legal First Middle Last Nickname

Address: ____
Street City State Zip

Home Phone (______) __________________________ Work Phone (______) ___________________________

Cell Phone (______) ___________________________ E-Mail: ____

Which phone number do you prefer we use to contact you? Home Cell Work

Sex: Male Female Social Security #: ______-_____-______ Birth date: _____/_____/_____ Age: _____

Employer: _______________________________________ Occupation: ________________________________

Closest Living Relative (Someone not living with you, in case of emergency.)

Name: ____ Relationship: ____________________________

Home Phone (______) ___________________________ Cell Phone (______) ___________________________

Other Information

Have you ever been diagnosed with cancer? _________ If yes, when? _______________________________

Worker's Comp Information

Date and time of the accident? _____/_____/_____ ___:___ AM/PM

Employer Information

Name:____ Phone:______________________

Address: ____

Contact Person: ____ Phone: ______________________

Attorney Information

Name:____ Phone:______________________

Address: ____

Please describe the accident: ____

____

____

Did you report the accident to your supervisor? ____ Yes ____ No

Supervisor's Name: ____

After the accident did your employer send you to a doctor? ____ Yes ____ No

If so, what did the doctor say was wrong? ____

____

____

Did you go to a doctor on your own? ____ Yes ____ No

Doctor's Name: ____

If so, what did the doctor say was wrong? ____

____

____

Are there other problems effecting your employment? ____

____

Do you favor one side of your body? ____ Yes ____ No

If so what do you favor? ____

Before the injury were you capable of equal work with others your age? ____ Yes ____ No

Have you injured this area before? ____ Yes ____ No

Patient Name: ____ **DOB:** ____/____/____

Please fill in complaint area for complaints you currently have resulting from the accident dated _____/_____/_____.

Complaint Area #1: ____

How often do you experience your symptom? ◻ Constantly (76-100% of the time) ◻ Occasionally (26-50% of the time) ◻ Frequently (51-75% of the time) ◻ Intermittently (1-25% of the time)

How would you describe the type of pain? ◻ Sharp ◻ Numb ◻ Dull ◻ Tingly ◻ Diffuse ◻Shooting ◻ Achy ◻ Shooting with motion ◻ Burning ◻ Stabbing with motion ◻ Sharp with motion ◻ Stiff ◻ Electric like with motion
◻ Other: ___________________________________

How is your symptom changing with time? ◻ Worse ◻ Staying the Same ◻ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? ______

How much has your symptom interfered with your work?
◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

How much has your symptom interfered with your social activities?
◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

Name and type of healthcare provider have you seen for this symptom: ____________________________________

How long have you had this symptom? ___________ **How do you think this symptom began?** _________________

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? ____________________ **What alleviates this symptom?** ___________________

What concerns you most about this symptom? ____

Complaint Area #2: ____

How often do you experience your symptom? ◻ Constantly (76-100% of the time) ◻ Occasionally (26-50% of the time) ◻ Frequently (51-75% of the time) ◻ Intermittently (1-25% of the time)

How would you describe the type of pain? ◻ Sharp ◻ Numb ◻ Dull ◻ Tingly ◻ Diffuse ◻Shooting ◻ Achy ◻ Shooting with motion ◻ Burning ◻ Stabbing with motion ◻ Sharp with motion ◻ Stiff ◻ Electric like with motion
◻ Other: ___________________________________

How is your symptom changing with time? ◻ Worse ◻ Staying the Same ◻ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? ______

How much has your symptom interfered with your work?
◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

How much has your symptom interfered with your social activities?
◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

Name and type of healthcare provider have you seen for this symptom: ____________________________________

How long have you had this symptom? ___________ **How do you think this symptom began?** _________________

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? ____________________ **What alleviates this symptom?** ___________________

What concerns you most about this symptom? ____

Patient Name: ____ **DOB:** ____/____/____

Complaint Area #3: ____

How often do you experience your symptom? ▫ Constantly (76-100% of the time) ▫ Occasionally (26-50% of the time)
▫ Frequently (51-75% of the time) ▫ Intermittently (1-25% of the time)

How would you describe the type of pain? ▫ Sharp ▫ Numb ▫ Dull ▫ Tingly ▫ Diffuse ▫Shooting ▫ Achy ▫ Shooting with motion ▫ Burning ▫ Stabbing with motion ▫ Sharp with motion ▫ Stiff ▫ Electric like with motion
▫ Other: __________________________________

How is your symptom changing with time? ▫ Worse ▫ Staying the Same ▫ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? ______

How much has your symptom interfered with your work?
▫ Not at all ▫ A little bit ▫ Moderately ▫ Quite a bit ▫ Extremely

How much has your symptom interfered with your social activities?
▫ Not at all ▫ A little bit ▫ Moderately ▫ Quite a bit ▫ Extremely

Name and type of healthcare provider have you seen for this symptom: ___________________________________

How long have you had this symptom? ___________ **How do you think this symptom began?** _________________

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? ____________________ **What alleviates this symptom?** ___________________

What concerns you most about this symptom? ____

Complaint Area #4: ____

How often do you experience your symptom? ▫ Constantly (76-100% of the time) ▫ Occasionally (26-50% of the time)
▫ Frequently (51-75% of the time) ▫ Intermittently (1-25% of the time)

How would you describe the type of pain? ▫ Sharp ▫ Numb ▫ Dull ▫ Tingly ▫ Diffuse ▫Shooting ▫ Achy ▫ Shooting with motion ▫ Burning ▫ Stabbing with motion ▫ Sharp with motion ▫ Stiff ▫ Electric like with motion
▫ Other: __________________________________

How is your symptom changing with time? ▫ Worse ▫ Staying the Same ▫ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? ______

How much has your symptom interfered with your work?
▫ Not at all ▫ A little bit ▫ Moderately ▫ Quite a bit ▫ Extremely

How much has your symptom interfered with your social activities?
▫ Not at all ▫ A little bit ▫ Moderately ▫ Quite a bit ▫ Extremely

Name and type of healthcare provider have you seen for this symptom: ___________________________________

How long have you had this symptom? ___________ **How do you think this symptom began?** _________________

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? ____________________ **What alleviates this symptom?** ___________________

What concerns you most about this symptom? ____

Patient Name: ____ **DOB:** ____/____/____

How would you rate your overall Health? ◻ Excellent ◻ Very Good ◻ Good ◻ Fair ◻ Poor

What type of exercise do you do? ◻ Strenuous ◻ Moderate ◻ Light ◻ None

Place a check if any of your immediate family members have the following:
◻ RA ◻ Diabetes ◻ Lupus ◻ Heart Problems ◻ Cancer ◻ ALS

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
◻	◻ Headaches	◻	◻ High Blood Pressure	◻	◻ Diabetes
◻	◻ Neck Pain	◻	◻ Heart Attack	◻	◻ Excessive Thirst
◻	◻ Upper Back Pain	◻	◻ Chest Pains	◻	◻ Frequent Urination
◻	◻ Mid Back Pain	◻	◻ Stroke	◻	◻ Smoking/Tobacco Use
◻	◻ Low Back Pain	◻	◻ Angina	◻	◻ Drug/Alcohol Dependance
◻	◻ Shoulder Pain	◻	◻ Kidney Stones	◻	◻ Allergies
◻	◻ Elbow/Upper Arm Pain	◻	◻ Kidney Disorders	◻	◻ Depression
◻	◻ Wrist Pain	◻	◻ Bladder Infection	◻	◻ Systemic Lupus
◻	◻ Hand Pain	◻	◻ Painful Urination	◻	◻ Epilepsy
◻	◻ Hip Pain	◻	◻ Loss of Bladder Control	◻	◻ Dermatitis/Eczema/Rash
◻	◻ Upper Leg Pain	◻	◻ Prostate Problems	◻	◻ HIV/AIDS
◻	◻ Knee Pain	◻	◻ Abnormal Weight Gain/Loss		
◻	◻ Ankle/Foot Pain	◻	◻ Loss of Appetite	**For Females Only**	
◻	◻ Jaw Pain	◻	◻ Abdominal Pain	◻	◻ Birth Control Pills
◻	◻ Joint Pain/Stiffness	◻	◻ Ulcer	◻	◻ Hormonal Replacement
◻	◻ Arthritis	◻	◻ Hepatitis	◻	◻ Pregnancy
◻	◻ Rheumatoid Arthritis	◻	◻ Liver/Gall Bladder Disorder		
◻	◻ Cancer	◻	◻ General Fatigue		
◻	◻ Tumor	◻	◻ Muscular Incoordination		
◻	◻ Asthma	◻	◻ Visual Disturbances		
◻	◻ Chronic Sinusitis	◻	◻ Dizziness		
◻	◻ Other:___________________________				

List all prescription and over-the counter medications you are currently taking: _______________________________
____

List all vitamins and other supplements you are currently taking: ____
____

What activities do you do at work? (check all that apply)
___ Travel a lot ___ Read a lot
___ Sit ___ Most of the day ___ Half of the day ___ A little of the day
___ Stand ___ Most of the day ___ Half of the day ___ A little of the day
___ Computer Work ___ Most of the day ___ Half of the day ___ A little of the day
___ Use the Phone ___ Most of the day ___ Half of the day ___ A little of the day

What activities do you do outside of work? (check all that apply) ____ Housework/laundry ____ Fixing/building things
_____ Reading _____ Watching TV _____ Exercising, describe ____
_____ Take care of children _____Other ____

Have you seen a Chiropractor before? ____ No ____ Yes If yes, how long ago? _____________________________

What were the results? ___ Great ___ Good ____ Fair ____ Mixed ____ Poor ___ Other:______________________

List all hospitalization, surgical procedures and significant past traumas: _____________________________________
____

Is there anything else the doctor needs to know about you or your health? _____________________________________

I verify these statements are true to the best of my knowledge:

Signature____ **Date:** _____________________________
Patient or Parent/Guardian

Symptoms **Patient Name** ______________________________ **DOB** ___/___/___

Please mark complaint area for complaints you currently have resulting from the accident on _____/____/_____.

Orthopedic & Musculoskeletal Symptoms

___ "Clunk" Sound with Neck Movements
___ Neck Pain
___ Upper Back Pain
___ Low Back Pain
___ Shoulder Pain ___ Left ___ Right
___ Upper Arm Pain ___ Left ___ Right
___ Elbow Pain ___ Left ___ Right
___ Forearm Pain ___ Left ___ Right
___ Wrist Pain ___ Left ___ Right
___ Hand Pain ___ Left ___ Right
___ Hip Pain ___ Left ___ Right
___ Upper Leg Pain ___ Left ___ Right
___ Knee Pain ___ Left ___ Right
___ Lower Leg Pain ___ Left ___ Right
___ Ankle Pain ___ Left ___ Right
___ Foot Pain ___ Left ___ Right
___ Jaw Pain
___ Clicking in Jaw
___ Pain when Chewing
___ Face Pain
___ Chest Pain
___ Stomach Pain
___ Bruise/Contusion to ___________________
___ Abrasion /Scrape to ___________________
___ Other Symptom ______________________
___ Other Symptom ______________________

Neurological Symptoms

___ Numb/Tingling Arm / Hand L R
___ Numb/Tingling Leg / Foot L R
___ Weakness Arm / Hand L R
___ Weakness Leg / Foot L R

Symptoms Associated with Injuries

___ Range of Motion Problems
___ Headaches
___ Muscle Spasms
___ Dizziness
___ Visual Disturbances
___ Sleep Disruption
___ Radiating Pain
___ Anxiety
___ Depression
___ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

___ Wanting to be Alone
___ Sleepiness
___ Nausea/Vomiting
___ Difficulty Concentrating
___ Day Dreaming/Staring Mindless Staring
___ Mood Swings
___ Agitation
___ Sadness or tearful
___ Blurry Vision
___ Double Vision
___ Disoriented
___ Confused
___ Difficulty Speaking
___ Feelings of Isolation from Others
___ Attention Problems
___ Appetite Changes
___ Pupils Different Sizes
___ Room Spins/Woozy Feeling
___ Balance Problems
___ Difficulty Walking
___ Difficulty Focusing/Easily Distracted
___ Very Tired
___ Dozing During the Day
___ Personality Change
___ Can't Remember Numbers
___ Reading Problems
___ Writing Problems
___ Difficulty with Adding/Subtracting
___ Poor Attention
___ Difficulty Learning New Things
___ Difficulty Understanding
___ Difficulty Remembering Things
___ Re-reading things to understand it
___ Anger
___ Difficulty Making Decisions
___ Change in Sexual Functioning
___ Reduced Confidence
___ Helplessness
___ Apathy (Don't Care)
___ Irritable
___ Change in Sense of Taste or Smell
___ Flashbacks to Accident
___ Impatience
___ Frustration
___ Hearing Problems
___ Difficulty Planning or Organizing

This form used courtesy of HBTInstitue.com

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Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation. However, we may use other procedures to help your body hold the adjustments.

I, ___________________________________, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____ ________/________/________
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, ______________________________being the parent or legal guardian of ________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child. Date of last menstrual period: ________/_________/________

____ ________/________/________
(Signature) (Date)

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HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

<u>You have the right to request a restriction of your protected health information.</u> This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

<u>You have the right to request to receive confidential communications from us by alternative means or at an alternative location.</u> **<u>You have the right to obtain a paper copy of this notice from us</u>**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

<u>You may have the right to have your physician amend your protected health information.</u> If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

<u>You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.</u>

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

<u>Complaints</u>

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **<u>We will not retaliate against you for filing a complaint.</u>**

This notice was published and becomes effective on/or before **<u>April 14, 2003.</u>**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature: __________________________ Print Name: _________________________Date______/______/______