# CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

**Today's Date**: _____

## PATIENT INFORMATION

**Name**: (Last, First, MI) _____ **Preferred Name**: _____

**Address**: _____ **City**: _____ **State**: _____ **Zip**: _____

**Home Phone**: _____ **Mobile**: _____ **Work**: _____

**Email**: _____ **Gender**: M / F **Marital Status**: Married / Single / Other

**Date of Birth:**_____ **Occupation:** _____ **Employer:**_____

**Spouse/Significant Other:** _____ **Children and Ages:**_____

**Are you:** Military Veteran / Active Duty Service Member / Reservist / National Guard / ROTC

**Referred by** *(name)***:** _____

☐ **Family** ☐ **Friend** ☐ **Co-Worker** ☐ **Doctor** ☐ **Other:**_____

***-CMS requires providers to report both race and ethnicity-***

**Ethnicity**: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**:_____

**Race**: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline

**Smoking Status**: Every Day / Some Days / Former / Never

## EMERGENCY CONTACT INFORMATION

**Full Name**: _____ **Preferred Contact Number**:_____

**Relationship**: Child / Parent / Spouse / Other: _____

**Primary Care Physician**: _____ **Doctor's Phone**: _____

## FINANCIAL INFORMATION -- ***Please allow us to photocopy your insurance card.***

**Self Pay (Cash)** **Insurance** **Personal Injury/Auto** **Other (please explain)** _____

**PRIMARY INSURANCE**: _____ **SECONDARY INSURANCE**:_____

**Policy Holder**: _____ **Policy Holder**:_____

**Relation to Insured**: Self / Spouse / Parent / Child / Other **Relation to Insured**: Self / Spouse / Parent / Child / Other

**Patient Name**: _____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

**Major Complaint**: _____

**When Did It Start (date):**_____ **What Event Caused It:**_____

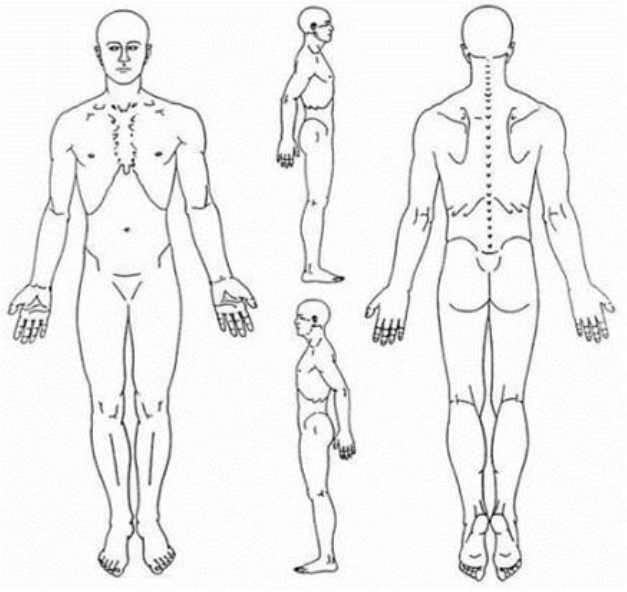
**Intensity:** None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

**Is The Complaint:** Constant / Off and On

**Is The Complaint**: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Pins and Needles Other:_____

**Does It Radiate/Shoot To Any Areas Of Your Body?** No / Yes **If YES, where:**_____

**DRAW AREAS OF COMPLAINTS:**



**What Makes It Better?** Ice / Heat / Rest / Movement / Stretching / OTC Meds / RX Meds / Chiropractic

**What Makes It Worse?** Sit / Stand / Walk / Lying / Sleep / Movement

**Who Else Have You Seen For This?** No One / DC / MD / PT / Massage / ER / Other:_____

**- Where:** _____

**Diagnostic Tests:** None / X-rays / MRI / CT / Other:_____ **When and Where:**_____

**Any Other Complaints**:_____

**Patient Name**: _____

**Does anyone in your IMMEDIATE family have a history of (circle condition):** ☐ **NONE**

**Heart Disease** If yes, who _____ **Stroke** If yes, who _____

**Cancer** If yes, who _____ Type_____ **Other Relevant Family History**:_____

**PAST HEALTH HISTORY:** (List even if it was 20 years ago…)

**Injuries, Traumas or Hospitalizations**: ☐ **NONE** _____

**Surgeries – Date, Type and Reason:** ☐ **NONE** _____

**Current Medications:** ***Did you bring a list? Can we make a copy?*** ☐ **NONE** _____

**Allergies to Medications**: *(List and reactions)* ☐ **NONE**

_____

**Are you interested in Weight Loss? Yes** ☐ **No** ☐

_____

## Are you ***CURRENTLY*** experiencing any of these symptoms? (Check all that apply)

**General:**
- ❑ Recent Intentional Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

**Musculoskeletal**:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Broken Bones
- ❑ Muscle Spasms/Cramps
- ❑ *None in this Category*

**Neurological:**
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Have you ever had a head injury?
- ❑ Had an auto accident? Year:_____
- ❑ *None in this Category*

**Gastrointestinal:**
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ *None in this Category*

**Cardiovascular & Heart:**
- ❑ Chest Pains
- ❑ Rapid or Heartbeat Changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ *None in this Category*

**Respiratory:**
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Tobacco Use
- ❑ *None in this Category*

**Eyes and Vision:**
- ❑ Wear Contacts/Glasses
- ❑ Blurred or Double Vision
- ❑ Eye Disease or Injury
- ❑ *None in this Category*

**Ears, Nose and Throat:**
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ *None in this Category*

**Mind/Stress:**
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ *None in this Category*

**Endocrine, Hematologic, and Lymphatic**:
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Cold Extremities
- ❑ Heat or Cold Intolerance
- ❑ Immune System Disorder
- ❑ *None in this Category*

**Skin and Breasts:**
- ❑ Rash or Itching
- ❑ Non-healing Sores
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ *None in this Category*

**Genitourinary:**
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Urinary Leakage or Bed Wetting
- ❑ Blood in Urine
- ❑ *None in this Category*

**Women Only:**

**Are you pregnant?**
- ❑ Yes-Due Date: _____
- ❑ No-Last Menstrual Period: _____
- ❑ Painful or Irregular Periods
- ❑ Urine Leakage with Coughing or Sneezing
- ❑ Urine Leakage with Laughing or Lifting
- ❑ *None in this Category*

**Pregnancies with Outcome & Date**

_____

_____

Other Conditions not listed:_____

**Is there anything else you would like the doctor to know?** _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature _____ Date_____

Doctor Signature _____ Date _____

# HIPAA Notice of Privacy Practices

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**DOYLE CHIROPRACTIC**

**PHONE# 704-947-7272 FAX# 704-947-7676**

**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 (PHJ) 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.

**I. Uses and Disclosures of Protected Health Information**

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**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.

**You have the right to request a restriction of your protected health information.** 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.

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

**You may have the right to have your physician amend your protected health information.** 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.

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

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.

**Complaints**

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. **We will not retaliate against you for filing a complaint.**

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

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:

Print Name:_____ Signature_____ Date_____

# Consent for Chiropractic, Acupuncture, Cupping, Laser, and Red-Light Bed Services

**By reading below I have been made aware:**

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.
5. There are services provided that may not be covered by insurance. These services include Cupping ($40), Acupuncture ($140), Laser ($100), Red Light Bed ($50). These services are optional, and we will inform you before such services are rendered.
6. Laser and Red Light cannot be performed over an area of active cancer. Please inform the doctor if you do have any active cancers. These therapies also cannot be performed over a developing fetus. Please let your doctor know if you are or become pregnant.
7. Cupping may cause bruising. This is generally short in duration and is a normal part of the cupping process.
8. Acupuncture can cause light bleeding. Although this is rare it is easily controlled with a sterile wipe and pressure for a few seconds.
9. Red Light Technology: Once the technology turns on, please remain still and do not get off the bed until the device turns off. If you need anything during your session or want to stop the session, you may then get up off the bed and notify staff.
    - Use the provided towel to cover any areas you do not wish to have fat reduced.
    - Please do not wear any lotion or oil on your skin on the days you come.
    - Please wear the provided eye protection during the entire session.
    - ALWAYS wear underwear or bathing suit when in the Red-Light Bed.
10. The human body has billions of processes, and each is different. Although we try to give all possible outcomes, please know it is impossible to know how everyone will respond to treatment. Please let the doctor know if you have any unusual signs or symptoms.

**Additionally:**

1. I have been afforded ample opportunity for questions and answers.

**Therefore, by signing below:**

**I consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

**I consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: _____ Date:_____

Printed Patient Name:_____

Witness Signature: _____ Date:_____