Welcome to Back Pain Relief Chiropractic!

Print out and complete the following pages to the best of your ability.

If you have had recent X-rays, MRI's or other diagnostic studies bring the reports with you to your office visit.

If you are under 18 you must be accompanied by a parent or legal guardian on each visit in our office.

Depending on your symptoms and health status there will be a few more papers to fill out when you get to the office, but this is a Great Start. Thank you.

Due to Privacy Concerns DO NOT fax or email these forms back to us. Bring them with you when you visit our office.

We are a Walk-In Clinic, but we request you schedule an appointment for your first visit. Our office phone number is 575-746-6375.

Welcome to the office. We look forward to serving you.

Dr. Andrews

Patient Name: _____ **Date:** _____

BASIC PATIENT INFORMATION

H. Phone: _____ W. Phone: _____ Cell Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ Email Address: _____

Sex: Male Female Other: _____ Marital Status: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Emergency Contact Name and Phone Number: _____

Have you ever received Chiropractic Care? Yes No If yes, by whom and when? _____

How did you hear about our office? _____

WORKERS COMP / ON THE JOB INJURIES
This office does NOT treat active on the job injuries. If you are here due to a recent on the job injury notify our staff immediately and we will make the proper referral for you. I certify my symptoms are not work related.
Patient or Representative Initials: _____

MOTOR VEHICLE / CAR ACCIDENTS
Motor Vehicle Injuries / Car Accidents are accepted on a case-by-case basis. If you are here due to a recent car accident inform our staff immediately. Do NOT fill out any further paperwork until speaking with our staff.
Patient or Representative Initials: _____

FINANCIAL RESPONSIBILIIY AND INSURANCE ASSIGNMENT
I acknowledge that my bill in this office is ultimately my responsibility regardless of possible insurance coverage or not.
Patient or Representative Initials: _____

If you want us to bill your insurance, **bring your insurance card and drivers license on your first visit and give it to our office staff to be copied.** By doing so, you authorize this office to take assignment of your insurance benefits. If insurance is billed, I authorize payment of medical benefits to Back Pain Relief Chiropractic, P.C. Dr. Thomas M. Andrews, D.C. for services performed.
Patient or Representative Initials: _____

If you have insurance and your coverage is through another person such as your spouse, guardian, etc.:
Policy Holder Name: _____ **Policy Holder Date of Birth:** _____

CELL PHONE USE
Please have the courtesy to step outside to make or take phone calls. Thank you.
Patient or Representative Initials: _____

Patient Name: _____ **Date:** _____

BASIC INTAKE INFORMATION

1. Past Health History:

A. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

B. Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies: _____

2. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases

□ Adopted/Unknown □ Cardiac disease below age 40

□ Psychiatric disease □ Diabetes □ Other _____ □ None of the above

A. Deaths in immediate family:

Cause of parents' or siblings' death	Age at death
_____	
_____	
_____	

3. Social and Occupational History:

A. Employer: _____ Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle:

Hobbies: _____

Level of Exercise: _____

Alcohol Use: _____

Tobacco Use: _____

Drug Use: _____

Diet: _____

4. Medications:

Medication	Reason for taking
_____	
_____	

Patient Name: _____ **Date:** _____

REVIEW OF SYSTEMS

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs
□ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain
□ Irregular heartbeat □ Aneurysm □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures
□ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors
□ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Loss of Bladder or Bowel Control
□ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements
□ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal Calculi/Kidney Stones □ Hematuria (blood in the urine) □ Incontinence (can't control)
□ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia
□ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease
□ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ GERD/heartburn □ None of the above
□ Other _____

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)
□ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes
□ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots
□ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **Oncological (cancer-related)** issues?
□ Fevers/chills/sweats/unexplained weight loss □ Abnormal Bleeding/Bruising
Current oncology disease: _____ Past Oncology disease: _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture
□ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants
□ Ankylosing Spondylitis □ Severe Osteoporosis □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder
□ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

Patient Name: _____ **Date:** _____

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 describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations 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 health care 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 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, marketing, and fundraising activities, and conduction 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 included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you 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 (the patient) give us (the office) permission to disclose and discuss any and all aspects of your case with the following person/s:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

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.

_____ _____
Signature of Patient or Representative **Date**

For minors only: _____ _____ _____
Representatives Relation to Patient **Printed Name of Representative** **Date**

Back Pain Relief Chiropractic, P.C., Dr. Thomas M. Andrews, D.C., C.C.S.T., F.I.A.C.A. 1108 S. 13th Street Artesia NM 88210
Phone: (575)746-6375 Fax: (575)746-6799