New Patient Paperwork

Beyond Limits
Health Intervention & Pain Relief Center

Name _____ ***Nickname*** _____

Address _____

City _____ ***State*** _____ ***Zip*** _____

Home #_____ ***Cell #***_____ ***Social Security #***_____

Email _____

Occupation _____ ***Unemployed/Disabled*** ___ ***Retired*** ____

Date of Birth _____ ***Height:*** ____***feet*** _____***inches*** ***Weight:*** _____***lbs.***

Spouse Name _____ ***Phone*** _____

Spouse's Occupation _____

How did you hear about the clinic (check off all that apply)?

Facebook	Event	Google	Newspaper	Family/Friend (Who?)_____	Other_____

Primary Care Physician Name _____

Phone Number _____ **Address** _____

When were you last seen there? _____

Can we send them updates on your treatment/condition? Yes__ No __

In the event of an emergency, please list the names and phone numbers of those we may release records to:

_____ _____

_____ _____

Health Situation Description

What is the most frustrating thing you struggle with on a daily basis?

How is this impacting your work? Relationships? Finances? Quality of life?

If you could wave a magic wand and instantly things would be different, what would your life look like? How would things be different? What would be possible for you that isn't possible right now?

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HEALTH HISTORY—PAST AND PRESENT

Have you ever had any of the following?

ILLNESS, CONDITIONS, INJURY	YES	NO	CURRENT
Chicken Pox			
Measles			
Mumps			
Anemia			
Arthritis			
Asthma			
Back Injury			
Bulging Disc			
Bronchitis			
Cancer			
Chronic Fatigue Syndrom			
Crohn's Disease, Ulcerative Colitis			
Degenerative Disc			
Diabetes			
Emphysema			
Epilepsy, Convulsions			
Excessive Thirst or Urination			
Fracture			
Gallstones			
Head Injury			
Heart Attack/Angina			
Heart Failure			
Herniated Disc			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Irritable Bowel			
Kidney Stones			
Leg Pain			
Low Back Pain			
Mononucleosis			
Morton's Neuroma			
Neck Injury			
Neck Pain			
Numbness in Hands or Feet			
Plantar Fascitis			
Pinched Nerve			
Pain in Hands or Feet			
Poor Circulation			

ILLNESS, CONDITIONS, INJURY	YES	NO	CURRENT
Poor Wound Healing			
Rheumatic Fever			
Sinusitis			
Sleep Apnea			
Sciatica			
Stroke			
Thyroid Disease			
Vascular Problems			
Other (describe)			

DIAGNOSTIC STUDIES,	YES	NO	DATE
Chest X-ray			
Mammogram			
EKG			
Colonoscopy			
Upper GI Series			
Barium Enema			
CAT Scan of Abdomen			
CAT Scan of Brain			
CAT Scan of Spine			
Liver Scan			
Bone Scan			
Neck X-rays			
Back X-rays			
MRI			
Bone Density Test			
Blood Tests			
Other (describe)			

TREATMENTS	YES	NO	DATE
Chemotherapy			
Spinal Injection			
Steriod Shots			
Implant Cord/Bladder Stimula-			
Pace Maker/Defribillator			
Other (describe)			

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Patient Health Information Consent Form

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 begin any health care operations, we 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 PHI, 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 this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic 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 this 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 with 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 effect 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 has 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, the chiropractic physician 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.

Signature: _____ **Date:** _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant, and the doctors and staff at Beyond Limits Health & Wellness have my permission to perform x-ray (s). I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period (first day): _____

Signature: _____ **Date:** _____