Patient Information & History

We are pleased to welcome you to Advanced Spinal Fitness. Please take a few minutes to complete your health profile as completely as you can. If you have questions, we'll be glad to assist you. We look forward to helping you and your family achieve maximum health through Chiropractic.

Name _____ Birth Date _____ Age _____

Gender: M F Single Married/Domestic Partnership Widowed Separated Divorced # of Children _____

Address_____ State _____ Zip _____

Primary Phone # _____ Alternate Phone # _____Email _____

Hobbies/Interests/Sports _____

Name of your M.D./D.O. _____ City _____ Phone _____

Emergency Contact Person _____ Relationship _____Phone # _____

Your Employer _____ Occupation _____

Spouse/Partner or Parent's Name _____ Phone # _____

This Account is paid by: You &: Spouse/Partner/Parent Worker's Comp Auto Ins. Medicare Other

Whom may we thank for referring you to Advanced Spinal Fitness? _____

Reason for Visit

Your reason for this visit: Specific Problem Prevention Wellness / Maximize Health Potential

Please list your symptomatic complaints (if any):

_____

_____

Have you ever seen a Chiropractor? Yes No If yes, when and describe your experience? _____

_____

Please circle all that apply, in regard to your Chief Complaint:

Is Pain getting: Worse Better Same Comes & Goes

Is Pain Interfering with: Work Hobbies Sports Family Sitting Standing Walking Sleeping Concentrating

Please complete the following sentences:

I am here because _____

My goal (s) for care is (are) _____

Health History & Health Habits

Pease list any drugs or supplements you are currently taking:

_____

_____

How many times have you taken antibiotics in the last 5 years? None 1-3 4-6 7-10 10+

Please circle any surgeries you have had: Spinal Surgery Heart Hernia Gall Bladder Cancer
Appendectomy Tonsillectomy Hysterectomy – Complete/Partial Joint Replacement

Other:_____

Have you ever been hospitalized when not for a birth or a surgery? _____

Car Accidents: How many? _____ When? _____

Work Injuries: How many? _____ When? _____

Lifting Injuries: How many? _____ When? _____

The condition of your spine and nervous system is an accumulation of everything that has happened to you from birth until now. Multiple uncorrected stresses over a lifetime result in layers of damage to your spine, which in turn can damage your organs and other parts of your musculoskeletal system. Please circle all that apply:

Childhood	**Activities**	**Work**	**Sleep**
Difficult Birth	Exercise/Lift Weights	Sit for a Living	Side
Forceps/Suction	Golf	Stand for Living	Stomach
C-Section	Tennis/Racquetball	Heavy Lifting	Back
Yanked by Arm	Jogging	Desk/Computer	2 or more Pillows
Heavy Backpack	Martial Arts	Work Longer than 8hrs.	Do you flip or roll your
Childhood Falls	Bowling	Stooping	mattress every 3 months?
Gymnastics	Contact Sports	Bending/Twisting	Y or N

Have you ever had, or do you currently have any of the following? (circle all that apply)

Heart Disease	Dizziness	Sinus Problems	Herniated Disc, Where? _____
High Blood Pressure	Arm Pain	Allergies	Numbness, where? _____
Cancer	Wrist Pain	Kidney Problems	Tingling, where? _____
Diabetes	Mid Back Pain	Ulcer/Colitis	Muscle Spasms, where? _____
Stroke	Shoulder Pain	Gout	Screws/Rods/Plates, where? _____
Lower Back Pain	Hip Pain	Hepatitis	Artificial Joints, where? _____
Leg Pain	Constipation	Difficulty Breathing	Recurring Infections, where? _____
Neck Pain/Stiffness	Indigestion	Asthma	Other _____
Headaches	Menstrual Cramps	Emphysema/Bronchitis	

Do you have a family history of: Cancer Diabetes Heart Disease Stroke High Blood Pressure

Women: Are you pregnant? Y or N Are you nursing? Y or N # of Pregnancies _____ # of Deliveries _____

Currently Using Birth control? Y or N If yes, what kind? _____ Date of Last Menstrual Period _____

Menopausal or Post-Menopausal? Y or N

Do you consume/use/do the following:

Alcohol	Y or N	Regular Exercise	Y or N
Coffee	Y or N	Organic Food	Y or N
Tobacco	Y or N	Vitamins/Supplements	Y or N
Recreational Drugs	Y or N	Purified Water	Y or N

I hereby authorize the Doctor to treat my condition, as he or she deems appropriate through use of chiropractic manipulation throughout my spine and/or extremities. Ay x-ray negatives will remain the proper of this office, being on file where they may be seen at any time while a patient at this office. The patient also agrees that he or she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medially diagnosed conditions, nor for any medical diagnosis.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

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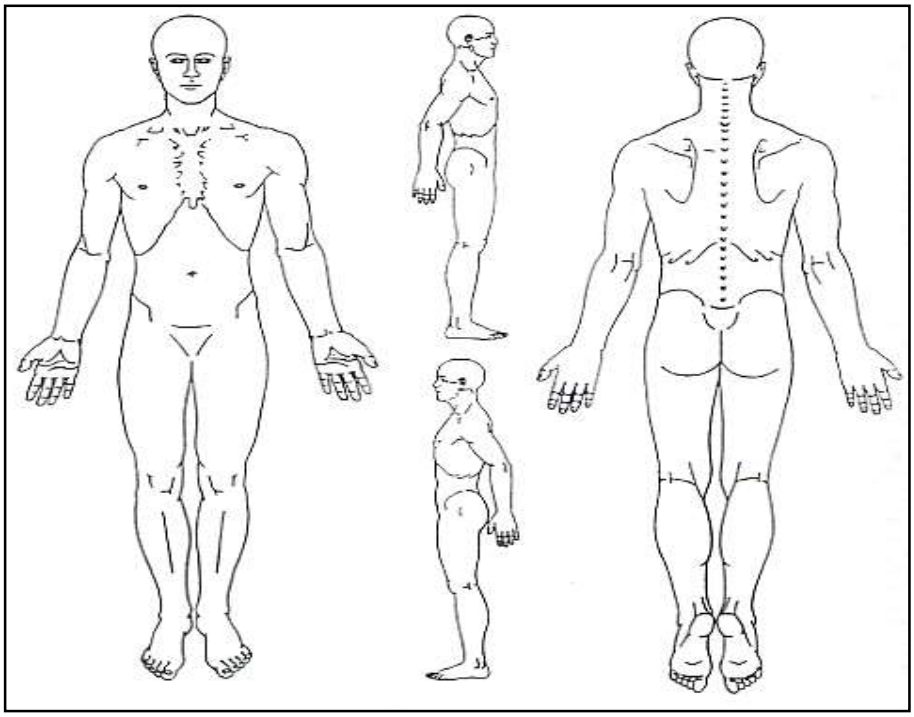
Pain Disability Diagram

Name: _____ Date: _____DOB: _____ Patient #: _____

Please circle the locations of your symptoms on the drawings. Also note the intensity and frequency of pain on the lines below. A one to ten scale is provided at the bottom for your reference. Use the blank lines for any areas of pain not named on the list.



1. **Headaches** Intensity: _____ Frequency: _____ days per week
2. **Neck Pain** Intensity: _____ Frequency: _____ days per week
3. **Arm Pain** Intensity: _____ Frequency: _____ days per week
4. **Upper-back Pain** Intensity: _____ Frequency: _____ days per week
5. **Mid-back Pain** Intensity: _____ Frequency: _____ days per week
7. **Low Back Pain** Intensity: _____ Frequency: _____ days per week
8. **Hip / Buttocks** Intensity: _____ Frequency: _____ days per week
9. **Leg Pain** Intensity: _____ Frequency: _____ days per week

_____ Intensity: _____ Frequency: _____ days per week

_____ Intensity: _____ Frequency: _____ days per week

Intensity Scale:

0 = No Pain
1-3 = Mild Pain
4-6 = Moderate Pain
7-9 = Severe Pain
10 = Maximum Pain

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Informed Consent to Treatment

All common health care treatments, including surgery, medications, injections, and spinal manipulation may have some risks associated with them. Doctors of Chiropractic are required to inform their patients regarding those possible risks. Please be informed of the following:

The most common side effect of chiropractic spinal or extremity manipulation is short term stiffness/soreness and/or headache. This side effect does not occur in every patient, is usually mild or moderate, but can occasionally be severe. This side effect is most commonly seen after the first several treatments and generally diminishes as treatment continues. Every care and precaution is taken in choosing adjustment style to minimize this side effect. Please inform your doctor if you experience any of the above.

While rare, some patients may experience muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.

There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does *not* establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that many patients may be consulting medical doctors and chiropractors with pain symptoms when they are in the early stages of a stroke. In essence, there is a stroke already in progress before treatment. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years, and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical treatments, medications, and procedures given for the same symptoms.

I acknowledge that I have read this consent and will discuss with my chiropractor any questions I have about the nature and purpose of chiropractic treatment in general and my treatment, as well as the contents of this consent. _____ (Initials)

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. In the event of the Doctors absence, I extend this consent to the chiropractic colleagues within this clinic. I intend this consent to apply to all my present and future care.

_____
Patient Name (Please Print)
(Parent/Guardian if Patient is a Minor)

_____ _____
Signature of Patient/Parent/Guardian **Date**

Acknowledgement of Privacy Policies

I hereby acknowledge that I have received a copy of the Advanced Spinal Fitness privacy policies. I understand that if I am not in agreement with the policies outlined, I am to speak with a representative of Advanced Spinal Fitness to make my concerns known and to revise the privacy policy as it applies to my protected health information, if possible.

_____
Patient Name (Please Print)
(Parent/Guardian if Patient is a Minor)

_____ _____
Signature of Patient/Parent/Guardian **Date**

Privacy Policies

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

In the course of your care as a patient at Advanced Spinal Fitness, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

This office may use name boards to acknowledge patients for referrals and birthdays in open areas where others may view your name only. No other Protected Health information would be used. You may also occasionally receive a nominal gift from this office.

Periodically, you may receive newsletters from this practice that highlight practice activities and information on products and services that will benefit your health.

You will have the opportunity to talk to your doctor and staff members in private. However, this practice provides treatment in an open area. This means that statements made by you or practice employees during treatment may be overheard by others. In addition, you will likely receive treatment within sight of other patients. If you have comments you wish to make privately when you are brought to the treatment area or during treatment, please inform the doctor or staff and we will accommodate your request. This open environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. You have the right to receive your ongoing care in a private setting. If you would like to be accommodated in this way, make the staff and/or doctor aware of this preference.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health-related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy policies with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy policy will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you may direct your complaint to the Secretary of Health and Human Services, or you may notify our staff of any complaint. We will not retaliate against you for filing a complaint. Direct any complaints or requests for further information about our privacy policies and practices to Dr. Nicole Whitehead.

This notice is effective as of January 15, 2007

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