## Patient Data Date: ___

Title: ☐Mr. ☐Mrs. ☐Ms ☐Miss (check one)

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Email: _____

Date of Birth: _____/_____/_____ Sex: ☐Male ☐Female Height_____Weight_____

Social Security Number: _____-_____-_____ Marital Status: ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Unemployed ☐Full Time Student ☐Part Time Student ☐Other

Do you have a family member that is a patient in the clinic? ☐Yes ☐ No Relationship: _____

## Insurance Data

Relationship to primary insurance policy holder: ☐Self ☐Spouse ☐Parent ☐Other:

If other than Self, please provide policy holder:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth_____/_____/_____ Social Security Number:_____-_____-_____

## Employer Data

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

## Emergency Contact

Contact Name:_____Contact Phone: (_____) _____-_____

## Primary Care Physician

Name:_____Contact Phone: (_____) _____-_____

Address:_____

City:_____State:_____Zip Code:_____

**How did you hear about our clinic? Or who referred you?**

- ❑ Family member
- ❑ Attorney
- ❑ Internet Website
- ❑ Health Class
- ❑ Friend
- ❑ Yellow Pages
- ❑ Billboard
- ❑ Brochure
- ❑ Physician
- ❑ Newspaper Ad
- ❑ TV Commercial
- ❑ Direct Mail Ad
- ❑ Employer
- ❑ Sign on Building
- ❑ Radio
- ❑ Other:

**If you selected 'Family Member', 'Friend', or 'Physician' please enter their name below:**

_____

**If you selected 'Internet Website' please describe:**

_____

**Are You Here For: (check all that apply)**

- ❑ Chiropractic Care
- ❑ Physical Therapy
- ❑Nutritional Consult
- ❑ Maintenance Care
- ❑ Other:

**Medical Conditions:**

- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Hypertension
- ❑ Psychiatric Illness
- ❑ Skin Disorder
- ❑ Stroke
- ❑ Bowel/Bladder Problems
- ❑ Abnormal Weight Gain/Loss
- ❑ Fever
- ❑ Corticosteroid Use
- ❑ Dizziness/Fainting
- ❑ Numbness in Groin/Buttocks
- ❑ Visual Disturbances
- ❑ Osteoporosis
- ❑ Pregnancy
- ❑ Severe Headaches
- ❑ Aortic Aneurism
- ❑ Muscle Weakness
- ❑ Blood Thinning Medications
- ❑ Other:

**Surgeries:**

- ❑ Appendectomy
- ❑ Cardiovascular Procedure
- ❑ Cervical/Lumbar Procedure
- ❑ Joint Replacement
- ❑ Other:

**Social History:**

- ❑ Caffeine used occasionally
- ❑ Caffeine used often
- ❑ Chew tobacco occasionally
- ❑ Chew tobacco often
- ❑ Drink alcohol occasionally
- ❑ Drink alcohol often
- ❑ Exercise not at all
- ❑ Exercise occasionally
- ❑ Exercise often
- ❑ Experience stress occasionall
- ❑ Experience stress often
- ❑ Smoke 1 pack or less per day
- ❑ Smoke more than 1 pack a day
- ❑ Other:

**Family History:**

- ❑ Arthritis
- ❑ Cholesterol
- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid
- ❑ Psychiatric
- ❑ Stroke
- ❑ High Blood Pressure
- ❑ Heart problems
- ❑ Other:
- ❑

**Occupational Activities:**

- ❑ Administration
- ❑ Business owner
- ❑ Clerical/secretarial
- ❑ Computer user
- ❑ Construction
- ❑ Daycare/childcare
- ❑ Executive/legal
- ❑ Food service industry
- ❑ Health care
- ❑ Heavy equipment operator
- ❑ Heavy manual labor
- ❑ Home services
- ❑ Household
- ❑ Light manual labor
- ❑ Manufacturing
- ❑ Medium manual labor
- ❑ Other:

**In general, would you say your overall health right now is:**

- ❑ Excellent
- ❑ Very good
- ❑ Good
- ❑ Fair
- ❑ Poor

**Are you taking any nutritional supplements/vitamins?**

❑ Yes ❑ No

If so, please name them:

**Who have you seen for your current symptoms?**

- ❑ No one
- ❑ Chiropractor
- ❑ Medical Doctor
- ❑ Physical Therapist
- ❑ Surgeon:
- ❑ Other:

First Name: _____ Last Name: _____Date:_____3

**When did you receive this treatment?**

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 – 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

**What tests have you had for your symptoms?**

❑ X-rays ❑ MRI ❑ CT Scan ❑ Bone Scan
❑ Other:

**When were these tests done?**

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 - 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

**Have you ever had similar symptoms in the past prior to this injury?**

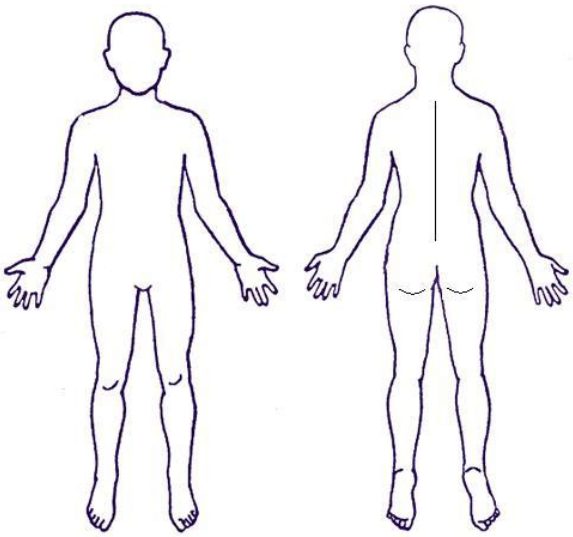
❑ Yes ❑ No

**If you have had treatment in the past for the same or similar symptoms, who did you see?**

❑ This Office ❑ Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other:

**By using the key below, indicate on the body diagram where you are experiencing the following symptoms:**

**# = Numbness** **X = Burning** **/ = Stabbing** **0 = Pins & Needles** **+ = Dull Ache**



Front Back

**Describe your symptoms:**_____

_____

_____

_____

**When did your symptoms start? Month**_____ **Day**_____ **Year**_____

**How did your symptoms begin?**_____

_____

_____

**Please circle your pain level:**

**No Pain** **Moderate Pain** **Worst Pain**

**1 2 3 4 5 6 7 8 9 10**

# Protecting Your Confidential Health Information is Important to Us

**For Law Enforcement:**
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of crime or in order to report a crime.

**Family, Friends and Caregivers:**
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

**To Coroners, Funeral Directors and Medical Examiners:**
We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

**Medical Research:**
Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirments and approval of an Institutional review board.

**Authorization to Use or Disclose health Information:**
Other than is stated above or where Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

**Patient Acknowledgement:**
Patient Name(s) **Print**:

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

X_____
Patient ( or Parent/Guardian) Signature

Date:_____/_____/_____

**Patient Rights**

This new law is careful to describe that you have the following rights related to your health information.

**Restrictions:**
*You have the right* to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

**Confidential Communications:**
*You have the right* to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

**Inspect and Copy Your health Information:**
*You have the right* to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let u know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

**Amend Your Health Information:**
*You have the right* to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.
Your request may be denied if the health information record in question was not created by our office, is not part of our records containing your health information are determined to be accurate and complete.

**Documentation of Health Information:**
*You have the right* to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14,2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

**Request a Paper Copy of this Notice:**
*You have the right* to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice.

*You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

# Informed Consent

When a patient seeks health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: muscle and joint soreness, fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I have read, or have had read to me, and fully understand the above statements and accept chiropractic care on this basis. All questions regarding Dr. Joshua Brooks' objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition(s) for which I see treatment.

_____ X_____ _____

Print Name Signature Date

## Consent to evaluate and treat a minor child:

I, _____being the parent or legal guardian of _____ have read and fully understand the above informed consent and hereby grant permission for my child to receive chiropractic care.

X_____ _____

Signature Date

First Name: _____ Last Name: _____Date:_____6

**Race** *(check one)*
❑ White ❑ Black/African American ❑MultiRacial ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese
❑ Native Hawaiian or other Pacific Island ❑Samoan ❑ Guamanian or Chamorro ❑Other_____
❑ I choose not to specify

**Ethnicity** *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

**Preferred Language** *(check one)*
❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German ❑ Tagalog
❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish ❑ Arabic ❑ Portuguese ❑ Japanese
❑ French Creole ❑ Greek ❑ Hindi ❑ Persian❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

**Do you currently smoke tobacco of any kind?** ❑ Yes ❑ Former smoker ❑ Never been a smoker
*If yes, how often do you smoke:* ❑ Current every day smoker ❑ Current sometimes smoker
*If yes, what is your level of interest in quitting smoking?*
0 1 2 3 4 5 6 7 8 9 10
*No interest* *Very Interested*

**Current medications, including frequency and dosage.** If there are no current medications, check here: ❑

| **Medication** | **Freq.** | **Dos.** | **Medication** | **Freq.** | **Dos.** |
|---|---|---|---|---|---|
| 1. | | | 5. | | |
| 2. | | | 6. | | |
| 3. | | | 7. | | |
| 4. | | | 8. | | |

**List any known allergies you have had to any medications.**
**If no allergies are known, check here: ❑**

1) _____ 3) _____

2) _____ 4) _____

**Has any doctor diagnosed you with Hypertension presently?** ❑ Yes❑ No If yes, describe: _
_____

**Has any doctor diagnosed you with Diabetes presently?**❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II
*If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*❑ Yes❑ No❑ Not Sure
*If yes, other comments regarding Diabetes:* _____

**Patient Privacy Question (Choose one):**

**In what city were you born?**_____

**What is your Mother's maiden name?**_____

**Signature of Patient X**_____