Office Use ONLY	#
Demographics	
Day 0	
Day 1	
Letter	
Call Slip	

Confidential Patient Health Record
Date: _____

Name_____ Date of Birth _____ Age _____

Address_____City_____ State_____ Zip_____

SS#_____-_____-_____ Male / Female Email Address _____ @ _____

Home #_____ Cell #_____ Cell Phone Carrier _____

Occupation_____ Employer_____ Work # _____

Employer's Address_____

City_____ State_____ Zip Code_____

Marital Status_____ Spouse's Name_____

Spouse's Occupation_____ Spouse's DOB_____

How Many Children Do You Have?_____ Children's Ages_____

Emergency Contact Name_____ Phone #_____

Do You Drink Alcoholic Beverages? ☐Yes ☐No How Often?/How Much?_____

Do You Smoke? ☐Yes ☐No How Often?/How Much?_____

Do You Exercise? ☐Yes ☐No How Often?/How Much?_____

Do You Have Any Allergies? (Specify)_____

Are You Pregnant? ☐Yes ☐No ☐Not Sure Date of Last Period?_____

Have You Ever Received Chiropractic Care? ☐Yes ☐No Last Visit Date?_____

Did They Take X-Rays? ☐Yes ☐No **Referred To This Office By**_____

What Medications Are You Currently Taking? _____

_____

What Surgeries Have You Had?_____

_____

List Any Recent Accidents or Falls_____

CHIEF COMPLAINT

What Is Your Primary Complaint? _____

How Long Have You Been Experiencing This Problem?_____

On A Scale of 1 to 10, How Severe Is It at It's Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

What Makes it Feel Better?_____ Feel Worse?_____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen By Another Doctor ☐Never Received Treatment For This Problem

SECONDARY COMPLAINT

What Is Your Secondary Complaint? _____

How Long Have You Been Experiencing This Problem?_____

On A Scale of 1 to 10, How Severe Is It At It's Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

What Makes it Feel Better?_____ Feel Worse?_____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen By Another Doctor ☐Never Received Treatment For This Problem

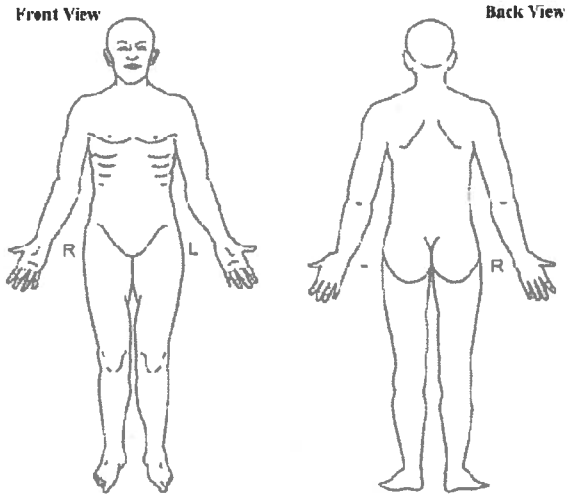
On the diag below, label ALL areas you are experien symptoms using the appropriate letter from the box below.

A = Aching	**C** = Cramping	**R** = Throbbing Pain	**N** = Numbness	**O** = Other
	B = Burning	**D** = Dull	**S** = Stiffness	T = Tingling

FAMILY HISTORY

The following family members have a same or similar problem as I do:

___ Mother
___ Father
___ Brother
___ Sister
___ Spouse
___ Child
___ Other
_____
_____



ADDITIONAL COMPLAINTS

Mark with an "**X**" Current Symptoms and "**O**" Past Symptoms

____ Arthritis
____Diabetes
____Swollen/Painful Joints
____Cancer
____Depressed
____Allergies/Sinus
____Trouble Sleeping
____Headaches
____Trouble Concentrating
____Learning Disablility
____Mood Changes
____Dizziness
____Neck Pain
____Numbness / Tingling in Hands / Legs / Feet
____Shoulders Feel Tired
____TMJ Pain
____Asthma
____Loss of Balance
____Upper / Mid Back Pain

____Shoulder Pain
____Ear Infections
____Low Back Pain
____Pain with Cough/Sneeze
____Chest Pain
____Hip Pain
____Gall Bladder
____Stroke
____Ulcers
____High / Low Blood Pressure
____Heartburn
____Heart Problems
____Kidney Problems
____Bed Wetting
____Diarrhea / Constipation
____Tremors
____Colon Trouble
____Prostate Problems
____Menstrual Problems
____PMS

____Menopausal Problems
____Foot Trouble
____Fainting
____Coughing Blood
____Pacemaker
____HIV Positive
____Tumors
____Eating Disorder
____Epilepsy
____Congenital Disease
____Alcoholism
____Drug Addiction
____Excessive Bleeding
____Heart Attack
____Migraines
____Pneumonia
____Anemia
____Mental Disorders
____Other
_____
_____

I understand and agree that health and accident insurance policies are an arrangement between insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credit to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate. It is understood and agreed the amount paid to the Doctor, for x-rays is for examination only and the X-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature_____ Date_____

Consent to Treat a Minor_____ Date_____

Guardian or Spouse's Signature Authorizing Care_____ Date_____

HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Advanced Spine Joint and Wellness Center. (Covered Entity) will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose medical records for the purpose(s) of receiving payment, insurance benefits, insurance denials, insurance audits, intent to reconcile account, intent to help patient, marketing and training purposes.

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information to: _____
_____ **[identify intended recipients and relation]**.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to 3591 Reserve Commons Dr Suite 100 Medina OH 44256.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of

HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Covered Entity will provide _____ [name of patient] with a copy of this signed authorization.

☐ **I understand the above agreement and decline a copy of HIPAA Notice**

Acknowledged and agreed to by:

PATIENT:

By_____ _____
Print Name_____ Date

Address:_____
_____
_____

or, ON BEHALF OF PATIENT

By_____ _____
Print Name_____ Date
As_____

Address:_____
_____
_____

ADVANCED SPINE JOINT
AND WELLNESS CENTER

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

Patient's Signature_____ Date _____

X-ray Questionnaire:

- ☐ I do NOT have any non-visible piercings that the doctor should be aware of.
- ☐ I do have piercings that are not visible to the naked eye that the doctors should be aware of.
  Specify: _____

For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____

_____

_____

Date of last menstrual period: _____

_____ _____

Patient's Signature Date

Neurological / MRI/ Vascular Patient Questionnaire

Name _____ Date _____

For any YES answer, please explain under comment and notify the doctor:

1. Do you suffer from neck pain in your shoulder, arms or hands? NO YES
Comment:

2. Do you have weakness, numbness or burning in your shoulder arms, or hands? NO YES
Comment:

3. Do your hands or arms fall asleep regularly? NO YES
Comment:

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
Comment:

5. Do you suffer from a loss of handgrip strength? NO YES
Comment:

6. Do you suffer with back pain with pain in your buttocks, legs, or feet? NO YES
Comment:

7. Do you have weakness, numbness or burning in your buttocks, legs, or feet? NO YES
Comment:

8. Do your legs or feet fall asleep regularly? NO YES
Comment:

9. Do you have reduced feeling (sensation) or swelling in your legs or feet? NO YES
Comment:

10. Do you suffer from cold hands or feet? NO YES
Comment:

11. Have you tried any medications such as anti-inflammatory? NO YES
If yes, what kind of medication?

12. Have you tried any physical therapy or Chiropractic treatments before? NO YES
If yes: When? For how long? What kind?

13. Have you had an MRI? NO YES
If yes: When? Who ordered it? What was it ordered for?

14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
If yes: When? What kind? Who ordered it?

15. If you have tried any treatment or medications, did this make your problem better? NO YES
Comment:

Note: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.