

One Source Family Chiropractic

Confidential Patient Information

Introduction and History

Name: _____	Date: _____
Home Address: _____	
Home Phone: _____	Work Phone: _____
Social Security #: _____	Date of Birth: _____
Employer's Name and Address: _____	
Occupation: _____	E-Mail Address: _____
Marital Status: M S W D	Number of Children: _____ Pregnant? _____
Spouse/Guardian Name: _____	
Spouse's Occupation/Employer: _____	
Name of person responsible for account: _____	
Do you have Medicare Coverage? _____	
Do you have Insurance that covers Chiropractic Care? _____	
Name of Insurance Company: _____	
Have you had Chiropractic care before? If so, when and by whom? _____	
Who may we thank for referring you? _____	

Why this form is important:

Our office focuses on your ability to be healthy. Our goals are to **first** address the issues that brought you to this office, and **second**, offer the **opportunity to improve your health potential in the future**. In order to give you the best possible Chiropractic care, we will need to discover any '**stresses**' that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.

Reason for consulting this office

Wellness / Prevention Care - *I wish to continue my Chiropractic Wellness Care.* Just answer the following questions that apply.

I have a specific health concern/pain - Please describe your current problem, including the effect it has had on your life: _____

Please describe the character of your pain (check all that apply)

- | | | | | | |
|--|-------------------------------------|---------------------------------------|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp/Stabbing | <input type="checkbox"/> Sharp/Dull | <input type="checkbox"/> Achy | <input type="checkbox"/> Dull | <input type="checkbox"/> Soreness | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Throbbing/Gnawing | <input type="checkbox"/> Numbness | <input type="checkbox"/> Shooting | <input type="checkbox"/> Gripping/Constricting | | |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Other: _____ | | | |

PLEASE TURN OVER →

How often are the complaints present?

- Constant Daily Weekly Monthly

When is the pain or symptoms worse?

- When you wake up During the day After work In the evening After eating
 While sleeping Same all day long

How bad is your pain or ache? Please circle a number (0= no pain, 10 = unbearable pain)

0 1 2 3 4 5 6 7 8 9 10

Since your problem began is the pain: increasing decreasing not changing

When did your problem begin: _____ (specific date, if possible)

Please draw on the diagram where you feel your symptoms: ↓

Do you sleep on your:

- Back Stomach Left Side Right Side

Physical Activity at work:

- Sitting more than 50% Light manual labor
 Heavy manual labor

General physical activity:

- No regular exercise program
 Light exercise program
 Strenuous exercise program

How would you rate your stress level:

- No Stress Minimal Stress
 Moderate Stress Greatly Stressed

Do you currently smoke? Yes No. If YES please indicate how many packs a day: _____

Number of years: _____ Have you smoked in the past? Yes No.

Who else have you seen for this condition? _____

Please describe any falls, auto accidents or major injuries (include Month/Year, Type of accident): _____

Please describe any and all past surgery: _____

Please list ANY and ALL medication (prescription and over the counter): that you are currently taking: _____

Please Circle All That Apply: PERSONAL: Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Polio, Asthma, Psoriasis. Other: _____

Please Circle Any That Apply: FAMILY: Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Polio, Asthma, Psoriasis. Other: _____

Please check all symptoms or areas where you have problems, even if they do not seem related to your current problem.

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Buzzing/Ringing in Ears | <input type="checkbox"/> Lungs | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heart | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Eyes/Vision | <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach | <input type="checkbox"/> Leg Pain/Cramps |
| <input type="checkbox"/> Concentration Loss | <input type="checkbox"/> Sinus | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Bladder | <input type="checkbox"/> Numb Feeling |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Liver | <input type="checkbox"/> Feeling of Pins/Needles |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Colon | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Loss Energy | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Kidney | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tired Mornings | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Loss of Taste/Smell | <input type="checkbox"/> Urination | <input type="checkbox"/> Fever | <input type="checkbox"/> Menstrual Problems |

- Do you drink bottled or filtered water: Yes No
- Do you belong to a health club or exercises regularly: Yes No

If you remember the details, what was your birth delivery like (i.e. – breach, c section, long): _____

Have you had any or all of your childhood vaccinations? All Some: _____

Any reactions to vaccinations? _____

Please list all supplements and vitamins you take: _____

How would you rate your health:

Yuk, I've never felt worse
1 2 3 4 5 6 7 8 9 10
Wow, I feel great!

How committed are you to improving your health:

Nah, not important
1 2 3 4 5 6 7 8 9 10
I want to be 100% healthy!

Do you want to live to be a healthy 85 years old? Yes No

What is 'being healthy' to you (check all that apply)?

- | | |
|---|--|
| <input type="checkbox"/> Not being sick | <input type="checkbox"/> Being symptom free |
| <input type="checkbox"/> Having energy to do what I want, when I want | <input type="checkbox"/> Not needing to take time off work |
| <input type="checkbox"/> To fully enjoy all aspects of life to the fullest extent possible. | |

What is your goal or expectations with Chiropractic care: _____

***Health is significant, but not necessarily serious
– we will do what we can to make each visit stress-free.***

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

One Source Family Chiropractic

Patient's Name _____

Guardian's Name _____

Description of the authority to act on behalf of the patient: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective.

- An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation.

- **Health** is a state of optimal physical, mental and social well being, not merely the absence of disease.

- **Subluxation** is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

Our chiropractic method of correction of subluxation(s) is by specific adjustments of the joints of the body.

I, the undersigned, hereby authorize One Source Family Chiropractic and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

Patient's Signature (or Guardian's Signature)

Date

OFFICE POLICY

- a. Insurance Patients must pay at time of service if insurance has not been confirmed and/or other arrangements have not been made. Medical insurance will almost never cover 100% of chiropractic services, therefore any patient should expect to have some out of pocket expenses.
- b. Cash patients must pay at the time of service if other arrangements have not been made.
- c. Personal Injury (i.e. auto injury) patients must have:
 1. Name of insurance company responsible for the injury.
 2. Valid claim number from insurance company.
 3. An adjuster's name who is handling the claim for the insurance company.All three must be provided before out of pocket expenses will be waived. If information cannot be confirmed, patient will be required to pay at the time of service. Once confirmation has been made we will return any fees paid and wait for insurance payments.
- d. Promotional offers, coupons, etc. – Patients coming in under promotions or special offers must understand that this reflects out of pocket cost whether or not you have insurance coverage. We will bill your insurance, if applicable, as this notifies your insurance company of the services we will be providing.
- e. Special Consideration – It is our policy to never turn anyone away from care based solely on financial reasons. Anyone wishing special consideration regarding fees must demonstrate three things.
 1. A sincere desire to regain their health,
 2. A willingness to offer some sort of fair exchange for care,
 3. *Real* financial hardship

Patient's Signature (or Guardian's Signature)

Date

X-RAY CONSENT

I understand that the purpose of the X-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic, or “unusual”, finding when reviewing this X-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment of the “unusual” finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

I fully understand the above and consent to chiropractic spinal x-rays, if they are found to be necessary.

Patient’s Signature (or Guardian’s Signature)

Date

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and One Source Family Chiropractic has my permission to perform an x-ray evaluation, if necessary. I understand that x-rays can be hazardous to an unborn child.

Date of last menstrual period: _____

Patient’s Signature

Date

The Chiropractic Office of One Source Family Chiropractic, PA

Privacy Notice

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 REVIEW IT CAREFULLY.

In the course of your care as a patient at One Source Family Chiropractic, PA 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, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not available at home and/or work to receive an appointment reminder, a message may be left for you. 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.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these 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 outlined above, will only be made upon your written authorization.

We normally provide information about your health 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, then 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 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 practices 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 notice 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 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 should direct your complaint to either:
Rafael A. Moreno, D.C. or Sarah J. Moreno, D.C. – 512-392-5750

If you would like further information about our privacy policies and practices please contact:
Rafael A. Moreno, D.C. or Sarah J. Moreno, D.C. – 512-392-5750

This notice is effective as of **April 10, 2006**. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Printed Name

Signature

Date

If you are a minor, or if you are being represented by another party:

Personal Representative (Printed)

Personal Representative (Signature)

Date

Description of the authority to act on behalf of the patient.