PATIENT CONFIDENTIALITY PERSONAL DATA

Today's Date: ____________________ Account # ______________________

PATIENT DEMOGRAPHICS

Name: ____ Birth Date: _____-_____-_____ Age: ________ ☐ Male ☐ Female
Name you wish to be called in our office: ____
Address: ____ City: ______________________ State: ______ Zip: ____________
E-mail Address: ______________________________________ Home Phone: ______________________________________
Mobile Phone: _______________________________________ Work Phone: _______________________________________
Social Security #: ____________________________________ Preferred Language: ________________________________
Employer: ____ Occupation: ______________________________________
Name of Spouse: _____________________________________ Spouse's Employer: _________________________________
Occupation: ____
Names and Ages of your children: ____
Name & Number of Emergency Contact: ______________________________ Relationship: ______________________
Race (circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer
Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer
Preferred Method of Communication: email / phone

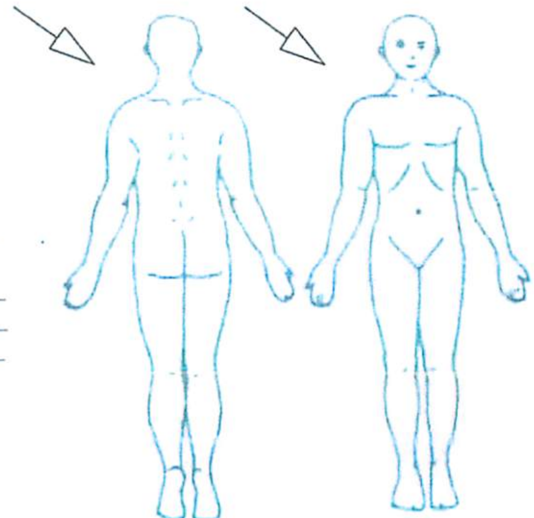
HISTORY of COMPLAINT(s)

Primary Problem: ____________________
____
____
When did problem begin? ______________________________
What relieves your symptom? Rest Ice Heat Movement Stretching Other ____________
What makes your symptom worse? Sitting Standing Walking Sleeping Overuse Other____________
Frequency: Off & On / Constant **Does the pain radiate?** No / Yes **Where?** ____________
How long does this problem last? ______________________________ **# of prior episodes?** ______
Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore
On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today (**Circle the number**): 0 1 2 3 4 5 6 7 8 9 10

Secondary Problem: ____________________
____
____
When did problem begin? ______________________________
What relieves your symptom? Rest Ice Heat Movement Stretching Other ____________
What makes your symptom worse? Sitting Standing Walking Sleeping Overuse Other____________
Frequency: Off & On / Constant **Does the pain radiate?** No / Yes **Where?** ____________
How long does this problem last? ______________________________ **# of prior episodes?** ______
Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore
On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today (**Circle the number**): 0 1 2 3 4 5 6 7 8 9 10

Tertiary Problem: ____________________
____
____
When did problem begin? ______________________________
What relieves your symptom? Rest Ice Heat Movement Stretching Other ____________
What makes your symptom worse? Sitting Standing Walking Sleeping Overuse Other____________
Frequency: Off & On / Constant **Does the pain radiate?** No / Yes **Where?** ____________
How long does this problem last? ______________________________ **# of prior episodes?** ______
Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore
On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today (**Circle the number**): 0 1 2 3 4 5 6 7 8 9 10

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms: **R** = Radiating **B** = Burning **D** = Dull
A = Aching **N** = Numbness **S** = Sharp/ Stabbing **T**= Tingling



Do your symptoms cause you to feel worse in the ☐ AM ☐ PM ☐ mid-day ☐ late PM
Have these Problems ever been treated by anyone in the past? ☐No ☐Yes
If yes, Who provided: ____
How long ago? ______ What **type** of treatment did you receive? ____________________
What were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable** please explain:
____
List any **medications** taken to treat these conditions: ____________________________
Did they help? ☐ No ☐ Yes If you still take them how often? ____________________
Have you ever been under chiropractic care? ☐ No ☐ Yes **If yes,** how long ago: ______
Name of Previous Chiropractor: ______________________________________
Are any of your problem(s) today the result of ANY **recent accident**? ☐ No ☐ Yes
If yes,
How long ago? ________ Please explain what type of accident: ____________________

PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure
___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis
___ Osteo Arthritis ___ Fracture ___ Diabetes ___ Other ________________________

2. PLEASE, identify ALL PAST and any unrelated current conditions you feel may be contributing your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS			
ADULT DISEASES			
SURGERIES			
CHILDHOOD DISEASES			

Reserved for doctor's use only → Systems reviewed with patient:
❑Musculoskeletal
❑Neurological

For Women Only: Are you pregnant? (circle one) **Yes** **No**

Medications: ________________________

Medication Allergies: ________________________

❑ I choose to receive a receipt of my clinical summary. (These are often blank as a result of the nature and frequency of chiropractic care) Check box only if you choose to receive.

SOCIAL HISTORY

1. **Smoking:** ❑cigars ❑ pipe ❑ cigarettes → *How often?* ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. **Alcoholic Beverage:** consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. **Recreational Drug use:** ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. How many years of school have you completed? ❑ 1-8 ❑ 8-12 ❑12-14 ❑14-16 ❑ 16 +

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes **If yes whom:**
❑ Grandmother ❑ Grandfather ❑ Mother ❑ Father ❑ Sister(s) ❑ Brother(s) ❑ Son(s) ❑ Daughter(s)
2. Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know
3. Any other hereditary conditions the doctor should be aware of ❑ No ❑Yes ________________________

Whom may we thank for referring you into our office today? ________________________

________________________ Patient or Authorized Person's Signature

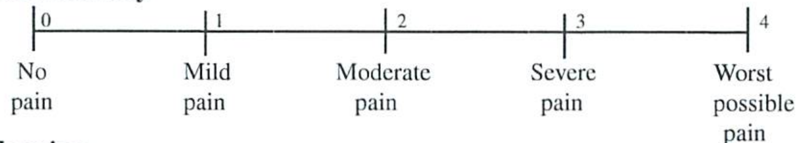
____ - ____ - ____ Date Completed

Functional Rating Index

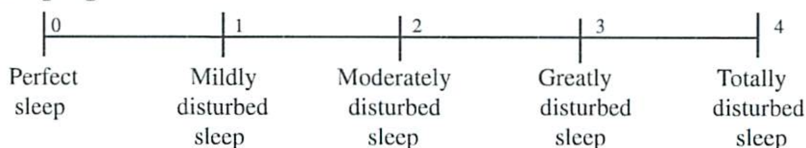
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

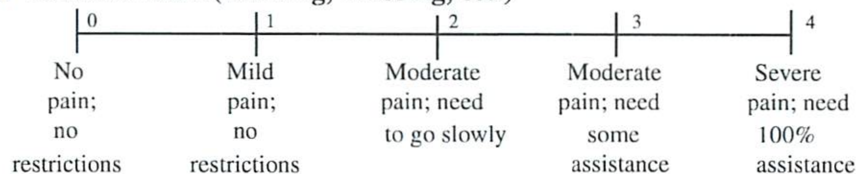
1. Pain Intensity



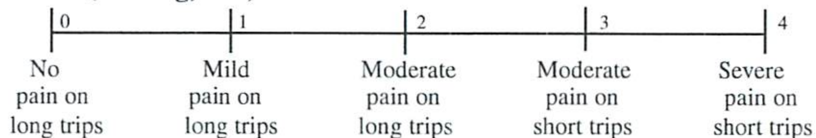
2. Sleeping



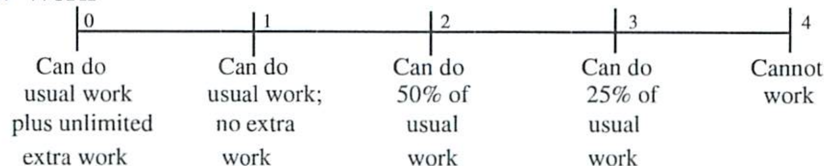
3. Personal Care (washing, dressing, etc.)



4. Travel (driving, etc.)

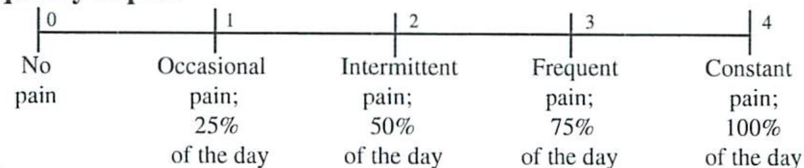


5. Work

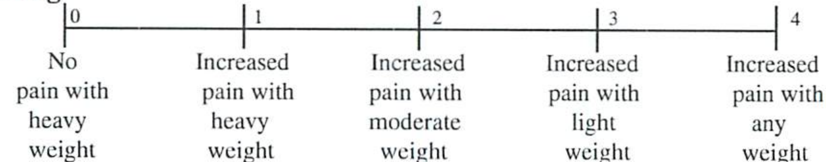


6. Recreation

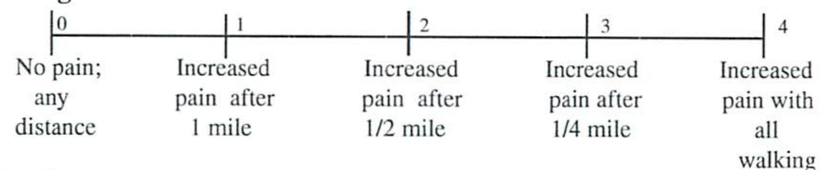
7. Frequency of pain



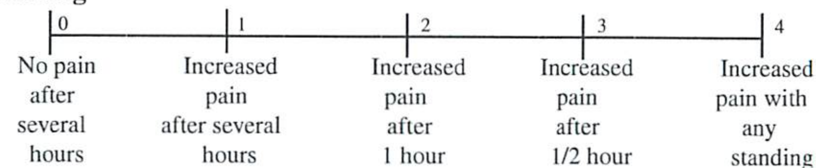
8. Lifting



9. Walking



10. Standing



Name ______________________________
PRINTED

Total Score ________

____
Signature

____
Date

© Institute of Evidence-Based Chiropractic
www.chiroevidence.com

Boehmer Chiropractic & Acupuncture
2216 Forum Blvd Ste 102
Columbia, MO 65202

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her Protected Health Information for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

☐ I, ________________________________(print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.

☐ I, ________________________________(print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier. I do understand that PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Patient Signature: ____ Date: ________________

ASSIGNMENT OF BENEFITS

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier.

If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

Assignment and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to paid in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt my settlement award(s).

Patient Signature: ____ Date: ________________

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include, sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures. One of the rarest complications associated with Chiropractic cares (occurring at a rate between one instance per one million to one instance per five million) is a cervical spine (neck) adjustment causing injury to a vertebral artery which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures enlisted by the doctor(s) in practice. This form was not signed until all my questions regarding treatment were answered to my complete satisfaction, and I conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor discussed with me that he/she deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

Patient Signature: ____ Date: ________________