

| PATIENT INFORMATION  |   |   |  |
|--|---|---|--|
| How were you referred to our office?   |   |   | Patient #  |
| FULL NAME  | DATE OF BIRTH   | HOME PHONE #  | CELL PHONE #   |
| STREET ADDRESS   | CITY  | STATE   | ZIP  |
| SOCIAL SECURITY NUMBER   | EMAIL   | MARITAL STATUS<br><input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed |  |
| EMPLOYER   | EMPLOYER ADDRESS AND PHONE  | OCCUPATION  |  |
| SPOUSE'S NAME  | SPOUSE'S DATE OF BIRTH  | SPOUSE'S EMPLOYER   |  |
| EMERGENCY CONTACT  | EMERGENCY CONTACT ADDRESS   | EMERGENCY CONTACT PHONE #   |  |
| INSURANCE INFORMATION  |   |   |  |
| IS THIS A RESULT OF AN AUTO ACCIDENT<br><input type="radio"/> YES <input type="radio"/> NO   |   | IS THIS A RESULT OF A WORKER'S COMPENSATION INJURY?<br><input type="radio"/> YES <input type="radio"/> NO                                 |  |
| NAME OF PRIMARY INSURANCE  |   | NAME OF SECONDARY INSURANCE   |  |
| <p>AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand I am responsible for all cost of chiropractic care, regardless of coverage.</p> <p><b>Patient Signature:</b> _____ <b>Date:</b> _____</p> <p>If patient is a minor please have guardian sign.<br/> <b>Guardian's Signature Authorizing Care:</b> _____ <b>Date:</b> _____</p> |   |   |  |
| HEALTH HISTORY   |   |   |  |
| PURPOSE OF THIS APPOINTMENT  | PLEASE CIRCLE BELOW TO INDICATE YOUR LEVEL OF PAIN<br>No Symptoms 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Extreme Symptoms |   |  |
| HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION BY A PHYSICIAN IN THE LAST YEAR? <input type="radio"/> YES <input type="radio"/> NO   IF YES, PLEASE DESCRIBE:  |   |   |  |
| PLEASE LIST ALL SURGERIES OR HOSPITALIZATIONS  |   | FRACTURES   |  |
| PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING   |   |   |  |
| PLEASE LIST ANY ALLERGIES TO MEDICATIONS   |   |   |  |
| YOUR FAMILY MEDICAL DOCTOR   |   | DATE OF LAST PHYSICAL EXAMINATION   |  |
| PLEASE CHECK ONE<br><input type="radio"/> Current every day smoker <input type="radio"/> Current some day smoker <input type="radio"/> Never Smoker <input type="radio"/> Former Smoker  |   | DRINK ALCOHOL<br><input type="radio"/> YES <input type="radio"/> NO   | USE RECREATIONAL DRUGS? <input type="radio"/> YES <input type="radio"/> NO |
| <b>HAVE YOU HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING SYMPTOMS WHICH ARE OR HAVE BEEN OF SIGNIFICANT DISTRESS TO YOU?</b>  |   |   |  |
| <input type="radio"/> Yes <input type="radio"/> No   Headaches   |   | <input type="radio"/> Yes <input type="radio"/> No   Loss of Balance  |  |
| <input type="radio"/> Yes <input type="radio"/> No   Neck Pain   |   | <input type="radio"/> Yes <input type="radio"/> No   Fainting   |  |
| <input type="radio"/> Yes <input type="radio"/> No   Stiff Neck  |   | <input type="radio"/> Yes <input type="radio"/> No   Unusual Bowel Patterns   |  |
| <input type="radio"/> Yes <input type="radio"/> No   Sleeping Problems   |   | <input type="radio"/> Yes <input type="radio"/> No   Diabetes   |  |
| <input type="radio"/> Yes <input type="radio"/> No   Back Pain   |   | <input type="radio"/> Yes <input type="radio"/> No   Indigestion  |  |
| <input type="radio"/> Yes <input type="radio"/> No   Chest Pains/Tightness   |   | <input type="radio"/> Yes <input type="radio"/> No   Joint Pain/Swelling  |  |
| <input type="radio"/> Yes <input type="radio"/> No   Dizziness   |   | <input type="radio"/> Yes <input type="radio"/> No   Weakness in Extremities  |  |
| <input type="radio"/> Yes <input type="radio"/> No   Shoulders/Neck/Arm Pain   |   | <input type="radio"/> Yes <input type="radio"/> No   Arthritis  |  |
| <input type="radio"/> Yes <input type="radio"/> No   Numbness in Fingers   |   | <input type="radio"/> Yes <input type="radio"/> No   Muscle Spasms  |  |
| <input type="radio"/> Yes <input type="radio"/> No   Numbness in Toes  |   | <input type="radio"/> Yes <input type="radio"/> No   Weight Loss/Gain   |  |
| <input type="radio"/> Yes <input type="radio"/> No   High Blood Pressure   |   | <input type="radio"/> Yes <input type="radio"/> No   Depression   |  |
| <input type="radio"/> Yes <input type="radio"/> No   Difficulty Urinating  |   | <input type="radio"/> Yes <input type="radio"/> No   Fatigue  |  |
| <input type="radio"/> Yes <input type="radio"/> No   Breathing Problems  |   | WOMEN ONLY: Is there any possibility you could be pregnant? <input type="radio"/> Yes <input type="radio"/> No                            |  |
| FAMILY MEDICAL HISTORY   |   |   |  |
| Rheumatoid Arthritis <input type="radio"/> Mother <input type="radio"/> Father   | Diabetes <input type="radio"/> Mother <input type="radio"/> Father  | Cancer <input type="radio"/> Mother <input type="radio"/> Father  |  |
| Heart Disease <input type="radio"/> Mother <input type="radio"/> Father  | Multiple Sclerosis <input type="radio"/> Mother <input type="radio"/> Father  | Stroke <input type="radio"/> Mother <input type="radio"/> Father  |  |
| DOCTOR'S SIGNATURE<br>Dr. Heath Schipp   |   | DATE  |  |

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. We may use your information to provide appointment reminders or recall notices (such as postcards or letters) or information about products and services that may be of interest to you. If you do not wish to receive these notices by mail you may opt out by checking the following:

I do not wish to receive mailings or appointment reminder calls

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Patient Name/Signature

Date