ADIO CHIROPRACTIC

Patient Health History

Today's Date _____/_____/_____ **Signature of Patient** _____

Patient Title: *(check one)* ❑Mr. ❑ Mrs. ❑Ms. ❑ Miss ❑Dr. ❑Prof. ❑Rev.

First Name_____**Nick Name**_____

Last Name_____**Middle Name**_____**Suffix**_____

Address 1_____

Address 2_____ **How did you hear about us?** _____

City_____**State**_____ **Zip Code**_____

Primary Phone_____**Secondary Phone**_____

Mobile Phone_____

Home email_____**Work Email**_____

By providing my email address, I authorize my doctor to contact me via the email address('s) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑Primary Phone ❑Secondary Phone ❑Mobile Phone ❑Home Email ❑Work Email

Date of Birth _____/_____/_____ **Age**_____**Gender** *(check one)* ❑Male ❑Female ❑Unspecified

Marital Status *(check one)* ❑Single ❑Married ❑Other **SSN**_____

Employment Status *(check one)*

❑Employed ❑ FT Student ❑ PT Student ❑Other ❑Retired ❑Self Employed

Pregnant ❑Yes ❑ No **How many weeks** _____

Race *(check one)*

❑White	❑Black/African American	❑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

Multi-Racial *(check one)* ❑Yes ❑No ❑Unknown

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	

Have you traveled out of the U.S. recently ❑Yes ❑No **If yes, where** _____

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑What is the name of your favorite pet? ❑ In what city were you born? ❑What high school did you attend?
❑What is your favorite movie? ❑What is your mother's maiden name? ❑ On what street did you grow up?
❑What was the make of your first car? ❑When is your anniversary?

Verification Answer to the Chosen question:_____
Answers must be at least 6 characters.

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 known. If there are no current medications, check here:❑

		Start Date			Start Date
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)** _____

Briefly list your main health problems: _____

_____

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: _____

Have you had an X-ray or CT scan or MRI of your spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height:_____inches **Weight:**_____ pounds **BP:**___ / ____

Describe Your Problem
(Fill in as necessary)

Symptom 1_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin?_____
- What makes the symptoms worse? (circle all that apply)
    - Bending neck forward/backward Tilting head to left/right Turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other_____
- What makes the symptoms better? (circle all that apply)
    - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other_____
- Describe the quality of the symptom (circle all that apply):
    - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other _____
- Does the symptom radiate to another part of your body? (circle one) Yes No
    - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one):
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

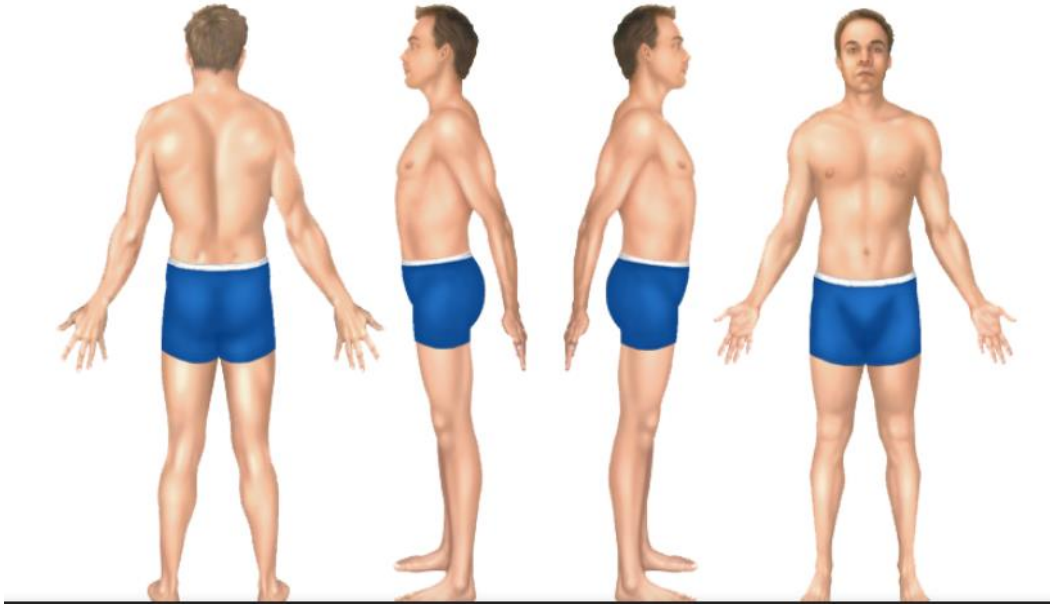
- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin?_____
- What makes the symptoms worse? (circle all that apply)
    - Bending neck forward/backward Tilting head to left/right Turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other_____
- What makes the symptoms better? (circle all that apply)
    - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other_____
- Does the symptom radiate to another part of your body? (circle one) Yes No
    - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one):
    - Morning Afternoon Evening Night Unaffected by time of day

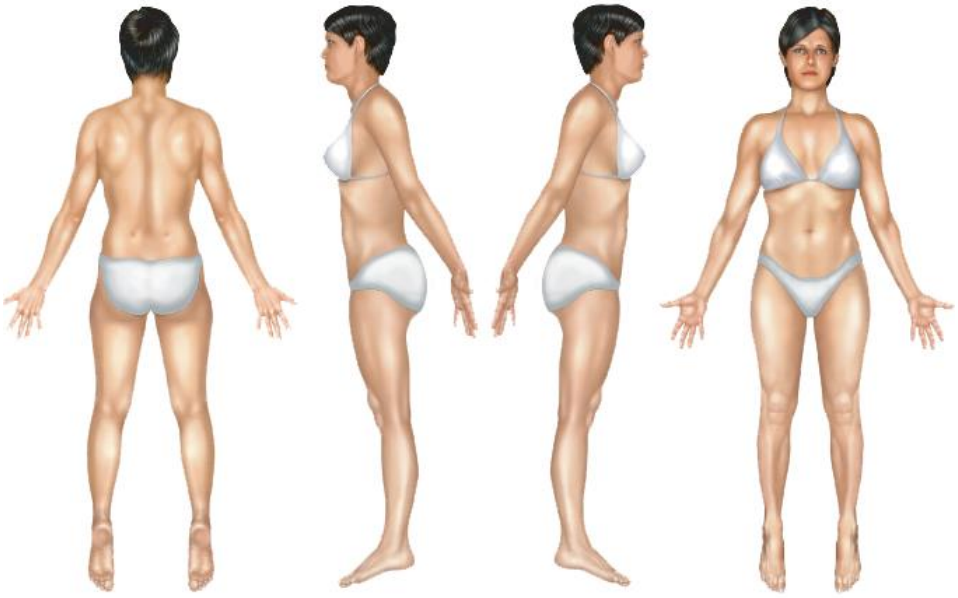
Symptom 3_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin?_____
- What makes the symptoms worse? (circle all that apply)
    - Bending neck forward/backward Tilting head to left/right Turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other_____
- What makes the symptoms better? (circle all that apply)
    - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other_____
- Does the symptom radiate to another part of your body? (circle one) Yes No
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one):
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin?_____
- What makes the symptoms worse? (circle all that apply)
    - Bending neck forward/backward Tilting head to left/right Turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other_____
- What makes the symptoms better? (circle all that apply)
    - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other_____
- Describe the quality of the symptom (circle all that apply):
    - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other_____
- Does the symptom radiate to another part of your body? (circle one) Yes No
    - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one):
    - Morning Afternoon Evening Night Unaffected by time of day





<u>Body Diagram</u>: Please indicate on the body where your symptoms are and what type of pain you are experiencing. Use the following to help describe the pain:

N- Numbness	PN- Pins and Needles
B- Burning	D-Dull Ache
S-Stabbing	P- Pain

<u>FAMILY HISTORY:</u> Do any Family Members have any of the following? Please indicate who has the condition.

Cancer_____ **Clotting Disorder**_____
Alzheimer's_____ **Diabetes** _____
Gastrointestinal Disorder_____ **Heart Disease**_____
High Cholesterol_____ **Hypertension**_____
Kidney Disease_____ **LungDisease**_____
Osteoporosis_____ **Psychological Disorder**_____
Septicemia_____ **Sudden Infant Death Syndrome**_____
Stroke_____
Any other serious illnesses not mentioned above: _____

Do you currently have or have you had:
(Please mark all that apply)

NEUROLOGICAL	Current	Past
Seizures		
Tremor		
Speech Problems		
Trouble Concentrating		
Headaches		
Muscle Weakness or paralysis		
Memory Loss		
Direct Head Trauma		
Loss of Consciousness		
Poor Coordination		
Numbness in groin		

MUSCULOSKELETAL	Current	Past
Hernia		
Arthritis or Gout		
Bursitis		
Fractured Bones		
Pain fails to improve with rest		
Pain greater than 4 weeks		
History of Osteoporosis		

CARDIOVASCULAR	Current	Past
Passing Out		
High Cholesterol/ Triglycerides		
Chest pain		
Heart Disease or Murmur		

ENDOCRINE	Current	Past
Diabetes		
Thyroid Trouble		
Liver Trouble		

INTEGUMENTARY/ALLERGIC	Current	Past
Skin Conditions		
Hay Fever		
Shingles		

HEMATOLOGIC	Current	Past
Anemia		
Bleeding or Bruising Tendency		

ENT	Current	Past
Sinus Problems		

CONSTITUTIONAL	Current	Past
History of Trauma		
Infection		
Unexplained Weight Loss		
Unusual Fatigue		
Dizziness/Poor Balance		
Change in Appetite		
Fevers/Night Sweats		
Low or High Blood Pressure		
History of Cancer		
Abdominal Pain		
Use of Corticosteroids		
Use of Anticoagulants		
Blood Clots		
Use of Birth Control		
Intravenous Drug Use		
Stroke		

RESPIRATORY	Current	Past
Asthma		
Shortness of Breath		
Chronic Cough		
Difficulty Breathing		

URINARY	Current	Past
More Frequent Urination		
Pain or Blood in Urination		
Kidney or Bladder infection		
Kidney Stones		

GASTROINTESTINAL	Current	Past
Recurrent Abdominal Pain		
Nausea		
Ulcers		
Heartburn		
Diarrhea or Constipation		
Hemorrhoids		
Loss of Bowel		
Loss of Bladder Control		
Vomited Blood		
Bloody or Black Stools		
Celiac Disease		

Cancellation Policy: We require a 24-hour cancellation for all of our services. Failure to do this will result in a cancellation fee.

Patient Signature: _____

HIPAA Privacy Authorization Form/ Notice of Privacy Practices

Authorization of use or disclosure or protected health information

(Required by the Health Insurance Portability and Accountability Act -45 CFR Parts 160 and 164)

Please read the follow and sign at the bottom:

I hereby authorize ADIO Chiropractic Center to view radiology studies that are necessary for my treatment. Requests for other studies and medical information will require a separate request form and my signature. *I understand that these studies may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Hum Immunodeficiency Virus (HIV) and other communicable diseases. Behavioral Health Care/ Psychiatric Care, Treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes the release of any such information.*

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, and/ or other purposes as I may direct.

This authorization shall be in force and in effect until I sign a written request to terminate this agreement. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re- disclosed by the person or organization that received the information.

I release ADIO Chiropractic Center, its employees, staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

By signing below you agree to the statements presented.

If you would like us to disclose your medical records, upon request, to any addition parties (i.e.; spouse, parent, providers) please provide Name, Date of Birth and Relationship:

_____

_____

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

_____

WITNESS SIGNATURE DATE