Patient Information

Patient Last Name:_____ **First:**_____ **MI:**_____

Address:_____ **City:**_____ **State/Zip:**_____ **Home Phone:**_____ **Cell Phone:**_____ **# of Children:**_____

SSN:_____ **Patient DOB:**_____ **Age:**_____ **Marital Status:**_____ **Email Address:**_____ **Would you like text message and/or email reminders of your appointments?**_____ **If you would like text message reminders, please write your mobile carrier**_____ **Patient Occupation:**_____ **Employer:**_____ **Employer Address:**_____ **Work Phone:**_____

Emergency Contact Information Contact

Name:_____ **Relationship:**_____

Address:_____ **City:**_____ **State/Zip:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Patient's Signature:_____ **Date:**_____

Parent/Guardian Signature:_____ **Date:**_____

Case History

Review or Systems

Your Top 5 Health Concerns

1. _____
2. _____
3. _____
4. _____
5. _____

Females Only

Have you had menstrual problems?_____

Have you ever taken birth control?_____

Is there any chance you could be currently pregnant?_____

Do you have any breast problems?_____

Past History

List any diseases that you have had in the past, including childhood disease:_____

_____

List any surgeries you have had. (Including appendix, tonsils, ear tubes, and wisdom teeth):

_____ **Date:**_____

_____ **Date:**_____

_____ **Date:**_____

_____ **Date:**_____

Have you ever been hospitalized for any reason other than surgery?_____

Medications: Please list all prescriptions/non-prescriptions medication you are taking on a regular and/or occasional basis_____

Patient Name:_____ **DOB:**_____

Social History

In what position do you usually sleep and how well?_____

Do you exercise on a regular basis?_____

Your diet is: Balanced:_____**Fair:**_____**Poor:**_____**Excessive:**_____**Rstrctd:**_____

Family History

Are there any diseases or conditions that are common among your family members?_____

_____

Patient Health History

Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	N	Hardening of the arteries	Y	N
Stroke	Y	N	Rheumatoid arthritis	Y	N
Slipped disc	Y	N	Fractured/broken vertebra	Y	N
Herniated disc	Y	N	Bleeding disorders	Y	N
Osteoporosis	Y	N	High blood pressure	Y	N
Drop attacks	Y	N	Blood in stool	Y	N
TIAis (pin or mini strokes)	Y	N	Cancer	Y	N
Kidney disease	Y	N	Prostate Disease	Y	N
AIDS	Y	N	Partial or complete paralysis	Y	N
Pregnant	Y	N	Nausea	Y	N
Taking birth control pills	Y	N	Vomiting	Y	N
Receiving hormone therapy (male)(female)	Y	N	Vertigo (spinning)	Y	N
Receiving chemotherapy	Y	N	Difficulty walking	Y	N
Receiving radiation therapy	Y	N	Uncoordinated	Y	N
Taking blood thinners	Y	N	Numbness or other sensory complaints	Y	N
Head Trauma	Y	N	Abnormal period	Y	N
A heavy smoker (1 or more packs a day)	Y	N	Loss of consciousness	Y	N
Surgical/medical implanted devices:	Y	N	Double vision	Y	N
Aortic clips	Y	N	Blurred vision	Y	N
Brain clips	Y	N	Tinnitus (ringing in ears)	Y	N
Artificial heart valves	Y	N	Speech problems	Y	N
Rods, pins, screws	Y	N	Clumsiness	Y	N
IUD	Y	N	Memory loss	Y	N
Surgical clips/wires	Y	N	Travel by car/truck	Y	N
Shunt	Y	N	Personality changes	Y	N
Neurostimulator	Y	N	Fever	Y	N
Dentures	Y	N	Recurrent headaches	Y	N
Pacemaker	Y	N	Diarrhea	Y	N
Hearing aid	Y	N	Use a tanning booth/bed	Y	N
Insulin pump	Y	N	Skin rash/infection	Y	N
Joint replacement	Y	N	A major fall	Y	N
Cochlear implants (ear)	Y	N	A minor fall	Y	N
Other implanted devices:	Y	N	An auto accident	Y	N
Metal fragments	Y	N	A work injury	Y	N
Bullets/shrapnel	Y	N	Loss of strength	Y	N
Body piercing	Y	N	Pain during bowel movements	Y	N

Do you currently have any of the following?

Integument System

Skin rash	Y	N	Hormone problems	Y	N
Skin lesion	Y	N	Hot flashes	Y	N
Changes in skin color	Y	N	Thyroid problems	Y	N
Itching (pruritus)	Y	N	Hormone therapy	Y	N
Hair changes	Y	N	Growth abnormalities	Y	N
Nail changes	Y	N	Metabolism changes	Y	N

Endocrine System

Cardiovascular System

Chest pain	Y	N	Changes in skin color	Y	N
Irregular heartbeat	Y	N	Stroke (full of pain)	Y	N
Shortness of breath	Y	N	Dizziness	Y	N
Fainting	Y	N	Cool hands or feet	Y	N
Fatigue	Y	N	Varicose veins	Y	N
Swelling of legs	Y	N	Mitral valve problems	Y	N

Genital/Urinary System

Pain during urination	Y	N	Visual problems	Y	N
Changes in urine flow	Y	N	Hearing loss	Y	N
Lump or mass in groin	Y	N	Loss of balance	Y	N
Kidney stones	Y	N	Loss of taste	Y	N
Chronic bladder infections	Y	N	Loss of smell	Y	N
Genital itching	Y	N	Loss of touch sensation	Y	N
Changes in urination frequency	Y	N	Temporary vision loss in one eye	Y	N
Changes in urine color	Y	N			

Special Senses

Male Reproductive System

Testicular pain	Y	N	Abnormal vaginal bleeding	Y	N
Prostate pain	Y	N	Painful menstruation	Y	N
Infertility	Y	N	Breast lump/mass	Y	N
Impotence	Y	N	Vaginal discharge/itching	Y	N
Discharge	Y	N	Nipple Discharge	Y	N
Lump or mass	Y	N	Infertility	Y	N
Male pattern baldness	Y	N	Abnormal periods	Y	N

Female Reproductive System

Current Treating Physicians

Primary Care Physicians:_____Phone #:_____
OB/GYN:_____Phone #:_____
Dentist:_____Phone #:_____

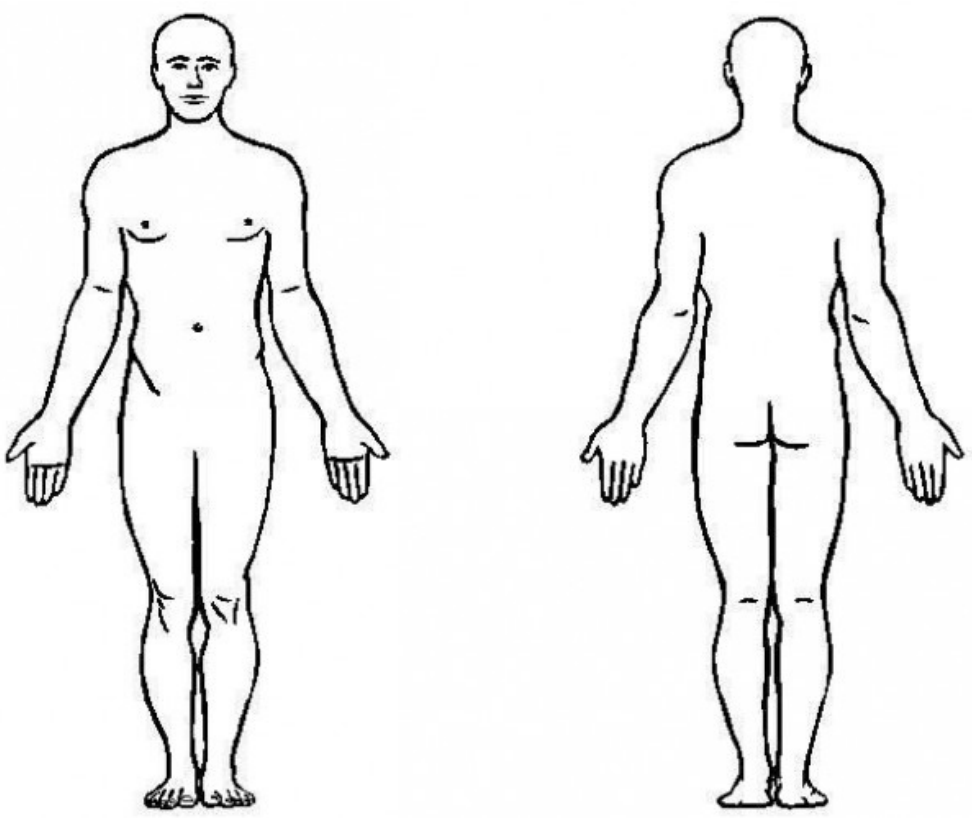
Any Additional Information

_____
_____
_____
_____

Patient Name:_____**DOB:**_____

Mark the appropriate letter for the symptom on the diagram.

A=ache, **S**=stabbing, **N**=numbness/tingling, **W**=weakness



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 PHI 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.
3. A patient's 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 effect 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 have 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

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

Name of Patient Date

MWI

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Create a Healthier You!
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