New Patient Intake

Cherry Street Chiropractic

CONFIDENTIAL HEALTH INFORMATION QUESTIONAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to assist you.

Your Name: ______________________________ **Date:** ______________

Address: ____

City: ____________ **State:** _____ **Zip:** ________ **Age:** _____ **Date of Birth:** _________

Home Phone: ____________ **Work:** ____________ **Cell:** ____________

SS#: ______________ **Drivers License #:** ______________

Marital Status: M S D W **Medicare Participant: YES NO**

Occupation: __________________ **Employer:** ____________________

Email: ____

IS YOUR VISIT DUE TO AN ACCIDENT? YES NO

Spouse's Name: ________________ **Date of Birth:** _______ **SS#:** _________

Spouse's Occupation: ______________ **Employer:** ________________

Employer's Address: ______________________________________

Emergency Contact: ______________ **Home Phone:** _______ **Work:** _______

Who referred you to this office so we may thank them? ____________________

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement or settlement.

Patient's Signature: ____________________________ **Date:** ____________

If patient is under 18 years of age please sign below:

Parent or Guardian's signature: __________________ Date : ___________

New Patient Intake

What is your primary complaint? ___________________________________

When did it begin? ____

How did it begin? ____

Describe your pain or other symptoms ___________________________________

On a scale of 1-10, with 10 being the worse pain possible, what is your pain level? ________

Check items that describe or accompany your complaints:

Difficulty with:
- ❑ Standing
- ❑ Sitting
- ❑ Bending
- ❑ Walking

Radiating Pain:
- ❑ Right Arm
- ❑ Left Arm
- ❑ Right Leg
- ❑ Left Leg
- ❑ Neck
- ❑ Base of Skull
- ❑ Ribs
- ❑ Shoulder (R/L)

Difficulty lifting:
- ❑ Light
- ❑ Moderate
- ❑ Heavy
- ❑ Repetitive

Extremity Pain:
- ❑ Foot (R/L)
- ❑ Ankle (R/L)
- ❑ Knee (R/L)
- ❑ Hip (R/L)
- ❑ Shoulder (R/L)
- ❑ Elbow (R/L)
- ❑ Wrist (R/L)
- ❑ Hand (R/L

- ❑ Headache
- ❑ Neck Pain
- ❑ Neck Stiffness
- ❑ Neck Restriction
- ❑ Upper Back Pain
- ❑ Upper Back Stiffness
- ❑ Mid-back Pain
- ❑ Mid-back Stiffness
- ❑ Low Back Pain
- ❑ Low Back Stiffness
- ❑ Rib Pain
- ❑ Fatigue
- ❑ Sleep Problems
- ❑ Digestive Issues
- ❑ Sinus/Allergy Problems

- ❑ Moody/Irritability
- ❑ Tension
- ❑ Mental Dullness
- ❑ Loss of Memory
- ❑ Dizziness
- ❑ Fainting
- ❑ Poor Balance
- ❑ Nervousness
- ❑ Irritability
- ❑ Depression
- ❑ Fear
- ❑ Confusion
- ❑ Head Seems Heavy
- ❑ Eye Strain/Pain
- ❑ Blurred Vision

- ❑ Double Vision
- ❑ Ringing/Buzzing Ears
- ❑ Loss of Taste
- ❑ Loss of Smell
- ❑ Shortness of Breath
- ❑ Chest Pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Cold Hands/Feet
- ❑ Unexplained Weight Loss/Gain
- ❑ Pin/Needles in Arms (R/L)
- ❑ Pins/Needles in Hands (R/L)
- ❑ Pins/Needles in Legs (R/L)

Does your problem/pain affect your work / hobbies / activities of daily living? ________________________________

Is the problem constant or does it come and go? ____

Does the problem prevent sleep? ____

Is the problem worse at any particular time of day? ____

Is the problem getting worse / getting better / staying the same? ____

Have you ever had this problem before? ____

What makes this problem worse? ____

What makes it better? ____

Do you have any other symptoms or problems that you feel are related to this one? ___________________________

Do you have any numbness / tingling / weakness into you extremities? _____________________________________

Have you had any changes in bowel / bladder habits? ____

Patient Name: ____Date:_________________

New Patient Intake

Please list any doctors or therapists that you have seen for this complaint:

1. ________________________________ Specialty _____________________________
2. ________________________________ Specialty _____________________________
3. ________________________________ Specialty _____________________________

Have you ever seen a chiropractor before? ____

Please list any previous serious illnesses, hospitalizations, and surgeries.

____

____

Please list any traumas, accidents, and injuries.

____

Please mark the conditions you have or had previously:

- ❑ Arthritis
- ❑ Asthma
- ❑ Anemia
- ❑ Back Pain/Spasms
- ❑ Cancer
- ❑ Concussion
- ❑ Convulsion
- ❑ Diabetes
- ❑ Digestion Problems
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Hand or Wrist Pain
- ❑ Headaches
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV
- ❑ Measles
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Neck Pain/Spasms
- ❑ Neuritis
- ❑ Numbness
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Sinus Problems
- ❑ Sciatica
- ❑ Tuberculosis
- ❑ Venereal Disease

Weight Concerns:

- Underweight
- Overweight by 10 - 25 lbs / 25 - 50 lbs / 50 - 100 lbs / 100+ lbs
- I have no concerns about my weight.

How would you describe your diet? ___________________________________

Do you exercise regularly? ____

Do you or have you ever smoked? ______________________________

Do you take any prescribed medications? Please list them.

____

Do you take any over the counter medications? Please list them.

____

Are you allergic to any medications? Please List: ____

Do you wear orthotics (shoe inserts)? Yes / No If yes, what type? ____

Are you pregnant: Yes / No If yes, due date: ____

Have you ever had any x-rays? ______ Were there any problems identified? _______________________________________

Do you have any family history of:
cancer / diabetes / high blood pressure / stroke / heart disease / high cholesterol / other

Any other health concerns from your family? ____

So, what is one thing we can set as a goal to work toward that you have wanted to do since this condition developed that you haven't been able to do? ____

Patient Name: ____Date:____________________

New Patient Intake

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

✧ **Relief Care** ✧ **Corrective Care**

✧ **I would like the Doctor to select the type of care appropriate for my condition**

Patient's Signature____Date______________________

Relief Care

Relief Care is the care necessary to get rid of your symptoms or pain but not the cause of it. It is the same as drying a floor that was getting wet from a leak without fixing the leak.

Corrective Care

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees from professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office. The x-rays will remain on file where they may be seen at any time while a patient of this office. The patient agrees that he or she is responsible for all bills incurred at this office.

Patient's Signature____Date__________

Consent to Treat a Minor ____Date__________

Guardian/Spouse Signature to Authorize Care____________________________________Date__________

New Patient Intake

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

What is Protected Health Information (PHI)?

Our practice values your privacy and is committed to protecting medical information about you. Protected Health Information, or "PHI," is ANY HEALTH INFORMATION that can be used to identify you, which we maintain or transmit in written, oral, or elecronic form. It may relate to your past, present, or future medical health or services.

This Notice of Privacy Practices tell you how we may use and disclose, your PHI that deals with your Treatment, Payment, or Health Care Operations (TPO), or for other lawful purposes.

It also describes your rights under the Health Insurance Portability and Accountability Sct (HIPAA) of 1996 (Public Law 104-191).

This notice is EFFECTIVE April 14, 2003

We will abide by all terms of this notice as required by HIPPA including our right to charge the terms of this notice, at any time. Any changes will be effective for your entire PHI that we maintain at the time of the change. We will prominently post any notice of changes in our office lobby and on our web site for your review. You may also request a revised notice by calling or writing our office.

Summary of Privacy Practices

This document describes how we safeguard your Protected Health Information (PHI) to make sure only the minimum amount of information is used and disclosed only to individuals with a legal right to access or view your PHI.

> **Use is the sharing, utilization, or examination of information by individuals within our practice.**
> **Disclosure is the release, transfer, or divulging of information by us to individuals, outside our practice.**
> **Consent is your granting us permission to disclose your PHI in order to provide you treatment, provide for payment of your health services, or manage our health care operations.**
> **Authorization is when you give us written permission to release your information to you, another person, or an organization.**

This document tells you the circumstances in which we can use or disclose your PHI.

1. **With Your Written Consent**
   Your personal health information will be used by staff or other health care professionals to offer treatment.
2. **With Your Written Authorization**
   Your personal health information will be disclosed to another professional organization (health care facility, insurance company) to assist us in providing payment for services.
3. **With or Without Your Consent or Authorization**
   If any county, state, or federal law requires that we use or disclose your personal health information by court order. If the law requires such action we will notify you of such disclosure.
4. **Your Rights**
   Your rights regarding your personal health information are listed in full in the full document located in this facility. You may access information at any time. You have the right to request that we not use or disclose any, or part of, your personal health information.
5. **Complaints**
   You have the right to complain to us if you believe your privacy rights have been violated by us. Any complaints should be in writing and state the nature of the complaint and how you may be contacted. These complaints should be directed to the privacy officer listed below.

Privacy Officer Contact Information:
Jill Pray
Cherry Street Chiropractic and Wellness Center
1825 East 15th Street
Tulsa, OK 74104
(918) 712-2220

New Patient Intake

Acknowledgment of Receipt of Notice of Privacy Practices

Cherry Street Chiropractic and Wellness Center
1825 East 15th Street Tulsa, OK 74104
(918) 712-2220

I _____________________________________ acknowledge that I have received a copy of the Notice of Privacy Practices of Cherry Street Chiropractic and Wellness Center, and a copy of this acknowledgment.

If you have any questions, please contact the privacy officer whose name and contact information is listed below.

____

Name of Patient or Personal Representative (Printed)

____

Signature of Patient or Personal Representative

____

Date

____

Personal Representative's Relationship or Authority

Privacy Officer:

Jill Pray
Cherry Street Chiropractic
1825 East 15th Street
Tulsa, OK 74104
(918) 712-2220

New Patient Intake

Authorization To Release Information

This form is for us to be able to request any other medical records from another facility that you have been seen at for the same condition that we are seeing you for.

I, ______________________________ ___________________ _________________ hereby authorize:
(Name of Patient) (Date of Birth) (Social Security #)

__________________________________, ____
(Name) (Address)
to release the following information to:

__________________________________, ____
(Name) (Address)

Please check all that apply:

- ❑ **Any information contained in the clinical record of the above patient regarding treatment or other care.**
- ❑ **The information contained in the clinical record of the above patient for the period from __________ to _________.**
- ❑ **The information contained in the complete clinical record of the above patient.**
- ❑ **Other ____**

For the following purpose: ____

This consent will expire on ________ or 6 months after the date of signature. I understand this authorization subject to revocation by me at any time except to the extent that action has already been taken reliance on it. A copy of this authorization will be valid.

I understand that my medical records may contain information that indicates that I have a communicable or venereal disease, which may include, but is not limited to diseases such as mepatitis, syphilis, gonorrhea, or human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).

With this knowledge, I give my consent to the release of all information in my medical records including any information concerning my identity and release medical group, it's agents and employees from any liability in connection with the release of the information contained therein.

___________________________________ ____________________ ___________________________
(Signature of Patient) (Date) (Signature of Witness)

____ _________________________________
(Signature of Parent, Guardian, or Legal Representative) (Nature of relationship to Patient)

____
(Reason patient is unable to sign)