

Why is this form important?

At Focus On Health, our mission is to help you make conscious healthcare decisions. Our goals are first to address the primary reason you came to the office and second, to offer you the opportunity to improve your quality of life through preventative wellness care. We all experience physical, chemical, and emotional stresses: these stresses accumulate and result in a decreased expression of your overall health. Answering the following questions will facilitate our ability to assess the challenges to your health potential and the function of your nervous system.

Full Name: _____ Nickname: _____ Today's Date _____
Address: _____ City: _____ State: _____ Zip _____
Home#: _____ Work#: _____ Mobile#: _____
Email: _____ Date of Birth: _____ Sex: Male Female
Marital Status: Single Married Divorced Separated Widowed SS#: _____
Occupation: _____ Employer: _____ # of years: _____
Emergency Contact: _____ Phone: _____ Relationship: _____

Who may we thank for referring you to our practice? _____ Relationship: _____
Primary Physician: _____ May we update them about your care? Y N

Chiropractic History:

Have you had previous chiropractic care? Y N If yes, whom? _____
Reason for care: _____ Did it help? _____
What type of care did you receive? Relief Correction Wellness/Preventative
Why are you changing chiropractors? _____

Insurance Information

Insured's Name: _____ Relationship to Insured? self spouse child other
Insured's Employer: _____ Insured's SS# _____ DOB _____
Primary Insurance: _____ Policy # _____ Group # _____
Secondary Insurance: _____ Policy # _____ Group # _____
Is today's visit due to: auto accident personal injury work accident old injury new injury
If any of the above, please notify the front desk

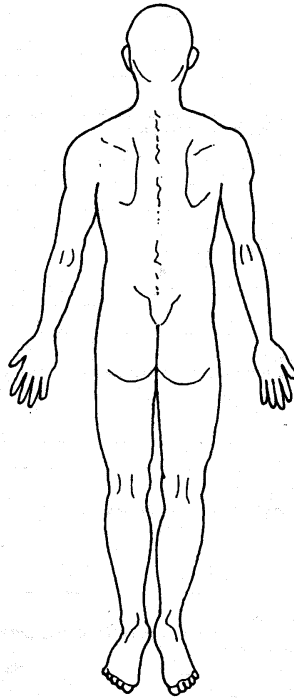
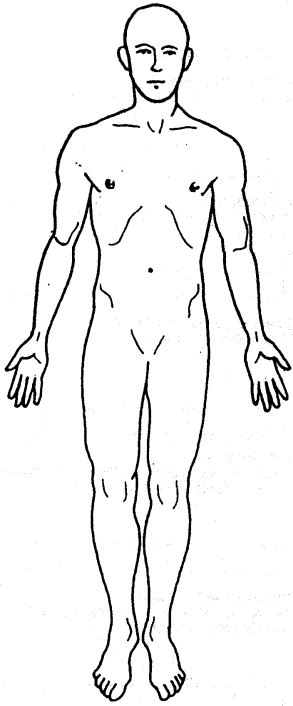
At Focus On Health, we are passionate about partnering with you in your health and wellness care. To understand your individual health goals, please check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Symptomatic/temporary relief | <input type="checkbox"/> Maximum Correction | <input type="checkbox"/> Improved Performance |
| <input type="checkbox"/> Restore Health | <input type="checkbox"/> Wellness and Prevention | <input type="checkbox"/> Other |

Patient Name: _____ Date of Exam: _____

On the diagram below, please illustrate any symptoms you may be experiencing by circling a body region or drawing a line along the path of pain and labeling that area with the appropriate letters:

Patient Signature: _____ (if guardian)



- A = Ache
- B = Burning
- D = Dull
- N = Numbness
- P = Sharp Pain
- S = Stiffness
- T = Tingling

Please identify your main complaints/concerns in the order of severity.

1. _____ Approximate date of onset: _____ Severity: (1 = very low pain: 10 = unbearable pain) _____
 _____ 1 2 3 4 5 6 7 8 9 10 _____ % of the time

<u>What makes it worse?</u>		<u>What makes it better?</u>		<u>Time it's at it's worst?</u>		<u>Setting it's at it's worst?</u>	
<input type="checkbox"/> Work	<input type="checkbox"/> Driving	<input type="checkbox"/> Rest	<input type="checkbox"/> Massage	<input type="checkbox"/> Upon waking	<input type="checkbox"/> Morning	<input type="checkbox"/> Work	<input type="checkbox"/> Driving
<input type="checkbox"/> ADL's	<input type="checkbox"/> Sitting	<input type="checkbox"/> Ice/heat	<input type="checkbox"/> Medication	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening	<input type="checkbox"/> Exercising	<input type="checkbox"/> Daily Activities
<input type="checkbox"/> Lifting	<input type="checkbox"/> Laying down	<input type="checkbox"/> Sitting	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Night	<input type="checkbox"/> Rest		
<input type="checkbox"/> Standing	<input type="checkbox"/> Other	<input type="checkbox"/> Stretching	<input type="checkbox"/> Other				
		<input type="checkbox"/> Exercise					

2. _____ 1 2 3 4 5 6 7 8 9 10 _____ % of the time

<u>What makes it worse?</u>		<u>What makes it better?</u>		<u>Time it's at it's worst?</u>		<u>Setting it's at it's worst?</u>	
<input type="checkbox"/> Work	<input type="checkbox"/> Driving	<input type="checkbox"/> Rest	<input type="checkbox"/> Massage	<input type="checkbox"/> Upon waking	<input type="checkbox"/> Morning	<input type="checkbox"/> Work	<input type="checkbox"/> Driving
<input type="checkbox"/> ADL's	<input type="checkbox"/> Sitting	<input type="checkbox"/> Ice/heat	<input type="checkbox"/> Medication	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening	<input type="checkbox"/> Exercising	<input type="checkbox"/> Daily Activities
<input type="checkbox"/> Lifting	<input type="checkbox"/> Laying down	<input type="checkbox"/> Sitting	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Night	<input type="checkbox"/> Rest		
<input type="checkbox"/> Standing	<input type="checkbox"/> Other	<input type="checkbox"/> Stretching	<input type="checkbox"/> Other				
		<input type="checkbox"/> Exercise					

3. _____ 1 2 3 4 5 6 7 8 9 10 _____ % of the time

<u>What makes it worse?</u>		<u>What makes it better?</u>		<u>Time it's at it's worst?</u>		<u>Setting it's at it's worst?</u>	
<input type="checkbox"/> Work	<input type="checkbox"/> Driving	<input type="checkbox"/> Rest	<input type="checkbox"/> Massage	<input type="checkbox"/> Upon waking	<input type="checkbox"/> Morning	<input type="checkbox"/> Work	<input type="checkbox"/> Driving
<input type="checkbox"/> ADL's	<input type="checkbox"/> Sitting	<input type="checkbox"/> Ice/heat	<input type="checkbox"/> Medication	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening	<input type="checkbox"/> Exercising	<input type="checkbox"/> Daily Activities
<input type="checkbox"/> Lifting	<input type="checkbox"/> Laying down	<input type="checkbox"/> Sitting	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Night	<input type="checkbox"/> Rest		
<input type="checkbox"/> Standing	<input type="checkbox"/> Other	<input type="checkbox"/> Stretching	<input type="checkbox"/> Other				
		<input type="checkbox"/> Exercise					

What is the **ONE THING** that motivated you to seek help from us today? (i.e. referral, pain...): _____

General Health and Wellness Questionnaire

How are these complaints/concerns affecting your quality of life? (Please check only those applicable to you).

- | | | | |
|---|----------------------------------|---|---------------------------------|
| <input type="checkbox"/> Work/School | <input type="checkbox"/> Walking | <input type="checkbox"/> Sitting | <input type="checkbox"/> Mood |
| <input type="checkbox"/> Exercise/Sports | <input type="checkbox"/> Eating | <input type="checkbox"/> Relationships | <input type="checkbox"/> Energy |
| <input type="checkbox"/> Recreation/Hobbies | <input type="checkbox"/> Sleep | <input type="checkbox"/> Daily Routines | <input type="checkbox"/> Other |

Lifestyle/Social History

On a scale of 1-10, please rank your psychological/emotional stress levels in each category (1=none / 10=extreme):

Occupational: _____ Personal: _____

On a scale of 1-10 (1=poor / 10=excellent), please describe your:

Eating habits: _____ Exercise habits: _____ Sleep: _____ General health: _____

Please list your unhealthy lifestyle habits (i.e. Smoking, eating junk food): _____

Medical History (Birth to Present)

Have you had any problems in the past or presently with any of the following systems of the body? (describe symptoms or list illness/disease)

Muscle/skeletal system (broken bones, dystonia, osteoporosis, etc): _____

Nervous System (MS, seizures, migraines, etc): _____

Gastro-intestinal (appendix, colitis, heartburn, etc): _____

Cardiovascular (heart attack, stroke, murmurs, etc): _____

Respiratory (asthma, cough, shortness of breath, etc): _____

Genito-urinary (incontinence, painful intercourse, etc): _____

Eyes, Ears, Nose, Throat (blurred vision, ringing in ears, etc): _____

Male or Female Specific (prostate, cysts, etc): _____

General (fatigue/allergies/sleep/diabetes/headaches/other): _____

Please list any medications you currently take and why: _____

Please list any nutritional supplements (i.e. vitamins, herbs) you take: _____

Have you had any accidents or trauma related to any of the following? (check all that apply)

- Automobile Sports Falls Abuse

If yes, please explain (type and date): _____

Hospitalizations and/or surgeries (type and date): _____

Family History

Please list any significant diagnosis or cause of death and age of any immediate family member (parents or siblings): _____

Are you healthier today than you were 5 years ago? Yes No Not Sure

· If so, what did you do to improve your health? _____

· If not, why do you think your health declined? _____

Will you be healthier 5 years from now than you are today? Yes No Not Sure

· If so, what are you planning to do to improve your health and if not, what could you do to improve your health rather than have it continue to decline? _____

- If there is a need for dietary changes to help you achieve a greater level of wellness, would you like to be informed? Yes No
- If there is a need for specific exercises, would you like to be informed? Yes No
- If there is a need for support in the psychological/mind/stress dimension of health, would you like to be informed? Yes No
- Would you like to be informed of what nutritional supplements or foods may help address your current health concerns or symptoms? Yes No

What are your expectations? As a result of chiropractic care, I would like to:

Notice of Privacy Rights Receipt Acknowledgement

I have received the Focus On Health Chiropractic Notice of Privacy Practices.

Signature of patient/legal guardian & relationship

Date

Witness Signature

Location where written acknowledgment was obtained

Office Use Only

- Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient/parent/legal guardian declined to acknowledge receipt.
- Patient/Parent/Legal Guardian stated they had already received the Privacy Notice
- Patient/Parent/Legal Guardian was directed to our clinic's website to view the Notice of Privacy Practice.
- The Notice of Privacy Practices was mailed to the patient/parent/legal guardian.
- Other: _____

Witness

Date

Agreement for Office Policies & Payment of Services:

In order to keep our fees from rising, and at the same time keep up with the monumental expenses of bookkeeping and billing services, we have opted to offer our patients these payment policies. This will help reduce our overhead, enabling us to pass the savings along to our patients.

A. I understand I am financially responsible, whether or not my insurance company pays, for all charges incurred by me. These charges are due and payable in full at the time services are rendered. I hereby assign my major medical insurance benefits, private insurance, and other health plans to Focus On Health Chiropractic. I understand that any filing of insurance is a courtesy to me. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

B. I hereby authorize release of any medical information, present and future, necessary to process this claim to those organizations/individuals involved.

C. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

D. No change to this agreement shall be effective unless in writing.

E. I understand the above information and guarantee the forms completed today were completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I have read the above policies and agree to abide by them.

Signature of patient/legal guardian & relationship

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'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 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.

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

Name of Patient

Signature of Patient

Date