CAVE SPRINGS CHIROPRACTIC

PATIENT INFORMATION

Patient First Name:_____ M.I.:_____ Last Name:_____

Address:_____City:_____

State:_____Zip:_____ E-Mail: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Sex: M / F

Marital Status: M S D W Birth Date:_____ Social Security #:_____

Employer:_____

Spouse's First Name: _____ M.I.:_____ Last Name:_____

Spouse's Social Security: _____ Birth Date: _____

Employer's Name: _____

CURRENT HEALTH CONDITION

Purpose of this appointment_____

Other Doctors seen for this condition?_____ Who?_____

Type of Treatment: _____ Results?_____

When did this condition begin?_____ Has this condition Occurred before? Y / N

Is your problem related to an injury?

☐ Yes ☐ No ☐ Car ☐ Accident ☐ Slip/Fall ☐ Work Related ☐ Other

If other, please describe:_____

Drugs you now take: _____

Do you wear a shoe lift? Y / N

Do you suffer from any condition other than that which you are now consulting us?

PAST HEALTH HISTORY

Please check and describe:

☐ Major Surgery ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia

☐ Back Surgery ☐ Broken Bones ☐ Other

Major Accident or Falls: _____

Hospitalization (Other than above):_____

HOW WERE YOU REFERRED?

How were you referred?

☐ Newspaper ☐ Insurance Company ☐ Health Presentation ☐ Yellow Pages ☐ Other

☐ Referred by:_____

IF THIS IS DUE TO AN AUTOMOBILE ACCIDENT OR A WORKERS COMPENSATION CLAIM, PLEASE LET THE FRONT DESK PERSON KNOW THAT! THANKS

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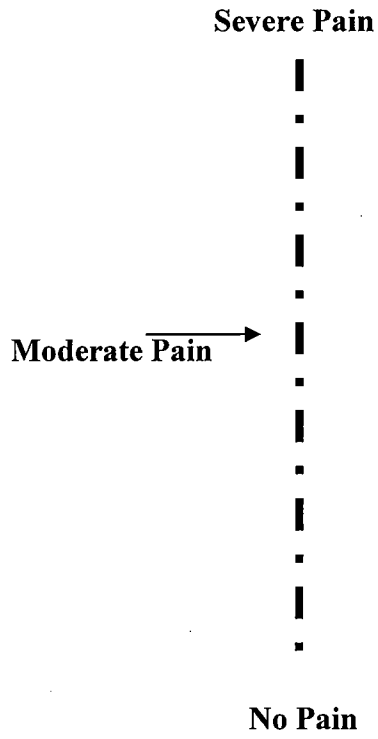
SYMPTOMS **NAME:**_____

If you are in pain, please mark the exact location of your pain on the diagram below, using the following letters to indicate the type of pain.

D = DULL	**T = TINGLING**	**B = BURNING**
S = SHARP	**N = NUMBING**	**T = THROBBING**



Frequency of pain:

☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Aggravated by:

☐ Lying ☐ Sitting ☐ Standing ☐ Bending
☐ Coughing ☐ Movement

Duration:

☐ Days ☐ Weeks ☐ Months ☐ Years

Comments:

_____

_____

_____

NAME:_____

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PATIENT CONFIDENTIAL HEALTH HISTORY

The items below may relate to your current condition. In the space in front of each item, enter **(Y)** if you have **EVER HAD** the problem, or enter **(N)** if you have **NEVER HAD** the problem. ***(Please put the year of problem.)***

GENERAL

1 ____ Fever
2 ____ Chills
3 ____ Night Sweats
4 ____ Loss of Sleep
5 ____ Fatigue
6 ____ Nervousness
7 ____ Weight Loss or Gain
8 ____ Allergies
9 ____ Bleeding Problems
10 ____ Anemia
11 ____ Diabetes
12 ____ Cancer
13 ____ Thyroid Disease/Goiter
14 ____ Alcoholism
15 ____ Drug Abuse

EAR, EYE, NOSE, THROAT

16 ____ Poor Vision
17 ____ Pain in Eye(s)
18 ____ Deafness/Difficulty Hearing
19 ____ Nosebleeds
20 ____ Nose Problems
21 ____ Sinus Trouble
22 ____ Dental Problems
23 ____ Hoarseness
24 ____ Tonsillectomy

GASTROINTESTINAL

25 ____ Poor Appetite
26 ____ Poor Digestion
27 ____ Difficulty Swallowing
28 ____ Belching or Gas
29 ____ Frequent Nausea
30 ____ Vomiting
31 ____ Vomiting Blood
32 ____ Pain over Abdomen
33 ____ Ulcer
34 ____ Black or Bloody Stools
35 ____ Liver Problems
36 ____ Gall Bladder Problems
37 ____ Jaundice
38 ____ Hernia
39 ____ Diarrhea
40 ____ Constipation
41 ____ Hemorrhoids
42 ____ Appendicitis

MEN ONLY

43 ____ Testicular Swelling/Pain
44 ____ Prostate Problems

RESPIRATORY

45 ____ Difficulty in Breathing
46 ____ Chroinic Cough
47 ____ Spitting Phelgm
48 ____ Spitting Blood
49 ____ Wheezing/Asthma
50 ____ Pneumonia
51 ____ Tuerculosis

CARDIOVASCULAR

52 ____ Irregular Heartbeat
53 ____ High Blood Pressure
54 ____ Pain Over Heart
55 ____ Previous Heart Trouble
56 ____ Ankle Swelling
57 ____ Varicose Veins
58 ____ Rheumatic Fever
59 ____ Stroke

GENITOURINARY

60 ____ Frequent Urination
61 ____ Painful Urination
62 ____ Blood in Urine
63 ____ Kidney Disease
64 ____ Urinary Infection
65 ____ Inabiity to Control Urination
66 ____ Difficulty Starting Urine Flow
67 ____ Get Up at Night to Urinate
68 ____ Breast Lump or Pain
69 ____ Veneral Infection
70 ____ Sexual Difficulties

SKIN

71 ____ Itching
72 ____ Bruising Easily
73 ____ Change in Mole(s)
74 ____ Skin Cancer
75 ____ Scars Location

NEUROLOGIC

76 ____ Weakness
77 ____ Twitching
78 ____ Tremors
79 ____ Headache
80 ____ Fainting
81 ____ Dzziness
82 ____ Convulsions
83 ____ Epilepsy/Seizures
84 ____ Numbing/Tingling
85 ____ Arm/Leg Pain
86 ____ Mental Disorder

MUSCULOSKELETAL

87 ____ Neck Stiffness/Pain
88 ____ Pain Between Shoulders
89 ____ Low Back Pain
90 ____ Swollen Joints
91 ____ Painful Joints
92 ____ Muscle Aches/Soreness
93 ____ Spinal Curvature
94 ____ Arthritis

WOMEN ONLY

95 ____ Painful Periods
96 ____ Excessive Flow
97 ____ Irregular Cycles
98 ____ Vaginal Burning/Itching
99 ____ Hot Flashes
100 ____ Date Last Period Began:
101 Date of Last Pap Smear:

EXERCISE

102 ____ None
103 ____ 1 - 2 times/week
104 ____ 3 - 5 times/week
105 ____ 6 - 7 times/week

HABITS

106 ____ Smoking ___# packs - day
107 ____ Drinking
108 ____ Recreational Drug Use
109 ____ Caffeine

FAMILY HISTORY
DO NOT INCLUDE YOURSELF

Include information on brothers, sisters parents and grandparents.

110 ____ Diabetes
111 ____ Thyroid Disease/Goiter
112 ____ Tuberculosis
113 ____ Kidney Disease
114 ____ High Blood Pressure
115 ____ Heart Disease
116 ____ Cancer
117 ____ Muscle, Bone or Nerve Disease
118 ____ Lung Disease
119 ____ Ulcers
120 ____ Arthritis
121 ____ Seizures/Strokes

MISCELLANEOUS

CAVE SPRINGS CHIROPRACTIC

DR. TERRY A. SURTIN

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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 available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Cave Springs Chiropractic 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 Cave Springs Chiropractic 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 the 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 summit 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, Cave Springs Chiropractic – Dr. Surtin has the right to refuse to give care.

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

_____ _____

Name of Patient Date