Patient Health History Form

Date

Patient Information

Patient Name: _____

Preferred Nickname (if any): _____

Guardian (if Patient under 18): _____

Birthdate: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: ☐ Married ☐ Single

Occupation: _____

Employer: _____

How Did You Hear About Us?

How did you hear about Dr. Vicky?

☐ Referred by: _____

Let us know who sent you, so that we can thank them for helping us help you!

☐ Google searched these words: _____

☐ Other: _____

Contact Information

Phone: _____ ☐ Cell Phone ☐ Home Phone

Email Address: _____

How do you prefer to receive appointment reminders? ☐ Phone Call ☐ Text Message ☐ Email

We provide appointment reminders one business day before you are scheduled.

24 hours notice is required to cancel or reschedule your appointment, so that we can make your time available for other patients in need. Late Cancellations and No Shows will result in a $30 charge for the unused appointment.

Sharing your Protected Private Health Information: Is there a person you authorize us to share your information with, should they ask? (Such as your next appointment date, status updates, etc)

☐ Yes - Name: _____ Relationship to Patient: _____

☐ No - All information will be kept private

Current Condition

What would you like assistance with today? _____

When did this problem begin? _____

Does the problem occur: ☐ Daily ☐ Weekly ☐ Monthly

☐ Intermittent (0-25% of the time) ☐ Occasional (26-50% of the time)

☐ Frequent (51-75% of the time) ☐ Constant (76-100% of the time)

Rate this problem from 1 ("I can live with this indefinitely") to 10 ("I will no longer tolerate this problem in my life"): _____

Rate this problem from 1 (barely noticeable) to 10 (worst experience imaginable): _____

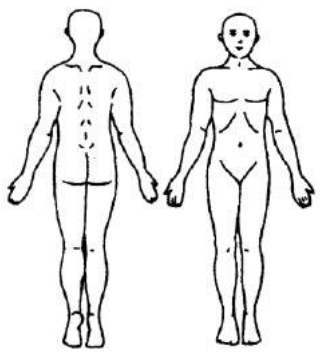
What have you tried for this problem so far? _____

What results did you experience? _____

What other problems are you experiencing? _____

What medications do you currently take? _____

What supplements do you currently take? _____



Please outline on the diagram the area of your discomfort

Past Health History Information

Please list all Surgeries and/or Operations you have had: _____

_____

Please list all Accidents or Major Falls you have had: _____

_____

Please list any additional Hospitalizations (other than above): _____

Previous Chiropractic Care: ❑ None ❑ Doctor's Name & Approximate Date of Last Visit: _____

Please Check the following based on your current lifestyle. Do You:

Smoke ❑ Yes ❑ No Packs/day: _____ Consume Caffeine ❑ Rarely ❑ Occasionaly ❑ Frequently

Drink Alcohol ❑ Yes ❑ No Drinks/week: _____ Exercise ❑ Rarely ❑ Occasionaly ❑ Frequently

Do your daily activities include: ❑ Lifting ❑ Bending ❑ Pulling ❑ Sitting ❑ Standing ❑ Heavy Labor ❑ None

Please Check ANY of the following diseases you have had:

❑ Pneumonia	❑ Anemia	❑ Diabetes: Type ____	❑ Pleurisy	❑ Other: _____
❑ Rheumatic Fever	❑ Measles	❑ Cancer: Type _____	❑ Arthritis	_____
❑ Polio	❑ Mumps	❑ Heart Disease	❑ Epilepsy	_____
❑ Tuberculosis	❑ Small Pox	❑ Thyroid	❑ Mental Disorders	_____
❑ Whooping Cough	❑ Chicken Pox	❑ Influenza	❑ Eczema	_____

Please Check ANY of the following conditions, if they have occurred in the past 3 months:

MUSCULO-SKELETAL
- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Leg Pain
- ❑ Walking Problems
- ❑ Difficulty Chewing
- ❑ Clicking Jaw
- ❑ Joint Stiffness

NERVOUS SYSTEM
- ❑ Nervousness
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold Extremities
- ❑ Tingling Extremities

GASTRO-INTESTINAL
- ❑ Poor Appetite
- ❑ Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Weight Trouble
- ❑ Abdominal Cramps
- ❑ Gas/Bloating After Meals
- ❑ Heartburn
- ❑ Black/Bloody Stool
- ❑ Colitis

GENITO-URINARY
- ❑ Bladder Trouble
- ❑ Painful Urination
- ❑ Excessive Urination
- ❑ Discolored Urine

GENERAL
- ❑ Fatigue
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

EENT
- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Ear Aches
- ❑ Hearing Difficulty
- ❑ Stuffy Nose

MALE/FEMALE
- ❑ Menstrual Irregularity
- ❑ Menstrual Cramps
- ❑ Vaginal Pain
- ❑ Breast Pain
- ❑ Breast Lumps
- ❑ Prostate Problems
- ❑ Sexual Dysfunction
- ❑ Infections

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Blood Pressure Problems
- ❑ Irregular Heartbeat
- ❑ Heart Problems
- ❑ Lung Problems
- ❑ Congestion
- ❑ Varicose Veins
- ❑ Stroke

FAMILY HISTORY

The following family members have the same or a similar condition as me:
- ❑ Mother
- ❑ Father
- ❑ Brother
- ❑ Sister
- ❑ Child

Authorization of Care

By signing below, I attest that the information in this New Patient Packet is accurate to the best of my knowledge.

I authorize payment of insurance benefits directly to this office. I understand and authorize this office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care with my other physicians and healthcare providers, as well as third party payors. I understand that I am responsible for all costs of my care, regardless of insurance coverage.

Complete Wellness Chiropractic Center wants me to know how my Patient Health Information is going to be used in this office and my rights concerning those records. I understand that if I would like to have a more detailed account of this office's policies and procedures concerning the privacy of my Patient Health Information, I may read the HIPAA Notice that is available to me before signing this consent.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

INFORMED CONSENT

I will use my hands or a small mechanical instrument to restore your joints to their proper alignment, so that they can return to functioning at their very best. This procedure is referred to as a chiropractic adjustment. I will perform this adjustment in as gentle and effective a manner as possible. During the adjustment, you may hear or feel a "pop" as part of the process. However, most of my patients do not experience any popping of joints during their treatments.

There are complications that, though rare, may occur as a result of an adjustment. These compilations include muscle strain, nerve irritation, disc injury, fractures, joint sprains, and dislocations. A very rare complication is stroke. The most common complaint following an adjustment, however, is a mild ache or stiffness at the site of treatment for 24 hours.

I take every precaution to minimize the risk of complications. These precautions include, but are not limited to, my taking your detailed health history, examining you for any pre-existing conditions which would cause a complication, and custom-tailoring your treatments to your specific needs. The nature of my gentle adjusting style further minimizes the risks of complications. I only administer treatment when I see that your health history, exam, & daily presentations indicate it is safe and appropriate to do so.

By signing below, you indicate that you have read and understand these possible complications, and that you consent to an examination and chiropractic treatment with me. You may revoke this consent at any time.

Print Patient's Name: _____

Parent/Guardian (if Patient is under 18): _____

Patient or Parent/Guardian Signature: _____

Today's Date: _____

Complete Wellness Chiropractic Center
Dr. Victoria Patterson
1272 A Jungermann Rd.
St. Peters, MO 63376
636-751-3150

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.

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. 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 obligated to agree to those restrictions only to the extent they coincide with state and federal law.
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. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, we have been trained in the area of patient record privacy and 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.
7. Patients have the right to file a formal complaint with our office and the Secretary of HHS about any possible violations of these policies and procedures without retaliation.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.

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

_____	_____	_____
Name of Patient (Print)	Signature	Date
_____	_____	_____
Name of Parent or Guardian	Signature	Date

For further information regarding this notice, please contact Dr. Vicky at (636) 751-3150.