

Patient Name: _____ **Date:** _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth _____ Age _____

Occupation _____

Employer _____

Emergency Contact and Phone Number: _____

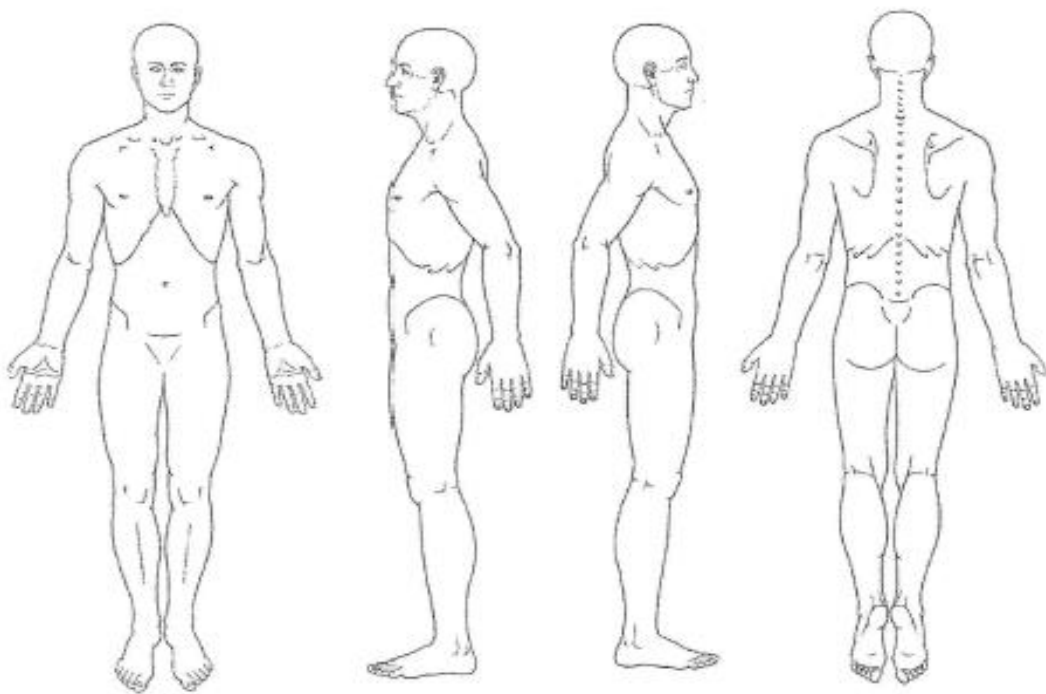
Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

Chief Complaint: _____ **Secondary Complaint:** _____

**Please mark off the
areas of your
complaint on the
diagram above
with the following
indicators:**
PPP = pain
NNN = numbness
TTT = tingling
BBB = burning
CCC = cramping
XXX = other



Patient Name: _____ Date: _____

1. Past Health History:**A. Surgeries:**

Date

Type of Surgery

_____	_____
_____	_____
_____	_____
_____	_____

B. Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies: _____**2. Family Health History:**

Do you have a family history of? (Please indicate all that apply)

- ☐ Cancer ☐ Strokes/TIA's ☐ Headaches ☐ Heart disease ☐ Neurological diseases
☐ Adopted/Unknown ☐ Cardiac disease below age 40 ☐ Psychiatric disease
☐ Diabetes ☐ Other _____ ☐ None of the above

A. Deaths in immediate family:

Cause of parents' or siblings' death

Age at death

_____	_____
_____	_____
_____	_____

Patient Name: _____ Date: _____

3. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle:

Hobbies: _____

Level of Exercise: _____

Alcohol Use: _____

Tobacco Use: _____

Drug Use: _____

Diet: _____

3. Medications:

Medication

Reason for taking

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Name: _____ Date: _____

Review of SystemsHave you had any of the following **pulmonary (lung-related)** issues?☐ Asthma/difficulty breathing ☐ COPD ☐ Emphysema ☐ Other _____ ☐ None of the aboveHave you had any of the following **cardiovascular (heart-related)** issues or procedures?☐ Heart surgeries ☐ Congestive heart/failure ☐ Murmurs or valvular disease ☐ Heart disease/problems
☐ Hypertension ☐ Pacemaker ☐ Angina/chest pain ☐ Irregular heartbeat ☐ Other _____
☐ None of the aboveHave you had any of the following **neurological (nerve-related)** issues?☐ Visual changes/loss of vision ☐ one-sided weakness of face or body ☐ History of seizures ☐ One-sided decreased feeling in the face or body ☐
Headaches ☐ Memory loss ☐ Tremors ☐ Vertigo ☐ Loss of sense of smell ☐ Strokes/TIAs ☐ Other _____
☐ None of the aboveHave you ever had any of the following **endocrine (glandular/ hormonal)** related issues or procedures?☐ Thyroid disease ☐ Hormone replacement therapy ☐ Injectable steroid replacements ☐ Diabetes ☐ Other _____
☐ None of the aboveHave you had any of the following **renal (kidney-related)** issues or procedures?☐ Renal calculi/stones ☐ Hematuria (blood in the urine) ☐ Incontinence (can't control) ☐ Bladder Infections
☐ Difficulty urinating ☐ Kidney disease ☐ Dialysis ☐ Other _____ ☐ None of the aboveHave you had any of the following **gastroenterological (stomach-related)** issues?☐ Nausea ☐ Difficulty swallowing ☐ Ulcerative disease ☐ Frequent abdominal pain ☐ Hiatal hernia ☐ Constipation
☐ Pancreatic disease ☐ Irritable bowel/colitis ☐ Hepatitis or liver disease ☐ Bloody or black tarry stools
☐ Vomiting blood ☐ Bowel incontinence ☐ Gastroesophageal reflux/heartburn ☐ Other _____ ☐ None of the aboveHave you had any of the following **hematological (blood-related)** issues?☐ Anemia ☐ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Aleve) ☐ HIV positive
☐ Abnormal bleeding/bruising ☐ Sickle-cell anemia ☐ Enlarged lymph nodes ☐ Hemophilia
☐ Hypercoagulation or deep venous thrombosis/history of blood clots ☐ Anticoagulant therapy ☐ Regular aspirin use
☐ Other _____ ☐ None of the aboveHave you had any of the following **oncological (cancer-related)** issues?☐ Fevers/chills/sweats/unexplained weight loss ☐ Abnormal bleeding/bruising
☐ Current/past oncology disease _____ ☐ None of the aboveHave you had any of the following **dermatological (skin-related)** issues?☐ Significant burns ☐ Significant rashes ☐ Skin grafts ☐ Psoriatic disorders ☐ Other _____ ☐ None of the aboveHave you had any of the following **musculoskeletal (bone/muscle-related)** issues?☐ Rheumatoid arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken bones ☐ Spinal fracture ☐ Spinal surgery ☐ Joint surgery
☐ Arthritis (unknown type) ☐ Scoliosis ☐ Metal implants ☐ Other _____ ☐ None of the aboveHave you had any of the following **psychological** issues?☐ Psychiatric diagnosis ☐ Depression ☐ Suicidal ideations ☐ bipolar disorder ☐ Homicidal ideations ☐ Schizophrenia
☐ Psychiatric hospitalizations ☐ Other _____ ☐ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Essential Health and Medicine / Dr Donnelly for services performed.

Patient or Guardian Signature _____

Date _____

Patient Name: _____ Date: _____

HIPAA 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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative_____
Date

Patient Name: _____ Date: _____

Printed Name _____

NEW PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
 - No
 - Anti-inflammatory meds
 - Pain medication
 - Muscle relaxers
 - Trigger point injections
 - Cortisone injections
 - Surgery
 - Massage
 - Physical Therapy
 - Chiropractic
 - Other _____

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
 - No
 - Anti-inflammatory meds
 - Pain medication
 - Muscle relaxers
 - Trigger point injections
 - Cortisone injections
 - Surgery
 - Massage
 - Physical Therapy
 - Chiropractic
 - Other _____

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM**Symptom 3** _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
 - No
 - Anti-inflammatory meds
 - Pain medication
 - Muscle relaxers
 - Trigger point injections
 - Cortisone injections
 - Surgery
 - Massage
 - Physical Therapy
 - Chiropractic
 - Other _____

Patient Name: _____ Date: _____

FINANCIAL POLICY

Your insurance policy is an agreement between you and the insurance company. It is important that you understand your health and accident benefits listed in your policy. You or your guardian(s) are personally responsible for any charges for services which are rendered to your account. There are many variations in the HMO's and PPO's of today. We request that you call your insurance company to get your Chiropractic Benefits within the first week of care.

As a courtesy to you, our office will also call your insurance company to verify insurance coverage, BUT this is not a guarantee of what the insurance company will pay. We will try, to our best ability, to ESTIMATE what your co-insurance/co-pay will be at each visit. It is our Office Policy to collect any deductibles, co-insurance, or co-pays at each visit unless other arrangements are made.

ONCE NOTIFIED BY THE INSURANCE COMPANY THAT SERVICES RENDERED ARE NOT PAYABLE UNDER THE "MEDICAL NECESSITY" CLAUSE IN YOUR CONTRACT, YOU AGREE TO ACCEPT FULL RESPONSIBILITY FOR SERVICES RENDERED.

Any overpayment made by your insurance company on your account will be refunded. Any balance not paid by the insurance company ultimately becomes your responsibility. If care is terminated by the patient or the doctor, payment for services is due in full immediately.

In signing this form, I acknowledge that I have read and understand this information.

Patient Printed Name_____
Patient Signature_____
Date

Patient Name: _____ Date: _____

INSURANCE PATIENTS: SIGNATURE ON FILE

PATIENT'S PRINTED NAME: _____

I request payment of authorized medical benefits be made on my behalf to Dr. Gregory Donnelly, D. C. for any services furnished to me by the list provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payments be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of HCFC-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance/co-pay, and the non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare or other insurance carrier.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government and/or other carrier benefits to the party who accepts assignment of benefits. I authorize payment of medical benefits to the undersigned physician or supplier for services described in submitted claims.

Patient's Signature_____
Date