# Patient History

Name:______________________________________________ Date:______ /______ / 20______

Street Address: ____________________________________________________________

City: ______________________________________ State: __________ ZIP: ________________

Social Security Number: ________ /______ /________ Date of Birth: ______ /______ /______

Age: ______ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/er

Employer: ___________________________________ Occupation: ________________________

Spouse's Name: __________________________ Number & Ages of Children: _________________

What is the best way to contact you? ☐ home ☐ work ☐ mobile: ________.________.________

Primary Care Physician: ____________________________________________________

Whom may we thank for referring you?_________________________________________

email address (You won't ever get spam from us. We promise.) ______________________________

In **detail**, please describe your current health concerns. Please be specific.

_ (See the word **detail** above? Please be specific in your description.) ______________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Date of Onset: __________ Worse at certain a time of day? ☐ Yes ☐ No When? ______________

Type of Pain (if present): ☐ Sharp ☐ Dull ☐ Throbbing ☐ Shooting ☐ Aching

Frequency of Symptoms: ☐ Constant ☐ Intermittent

Duration of Symptoms:_______________________________________________________

Are symptoms interfering with: ☐ Work ☐ Sleep ☐ Daily Activities ☐ Sports ☐ Hobbies

Have you seen another health care provider for this condition? ☐ Yes ☐ No

If yes, who and when? ________________________________________________________

Have you been under drug / medical care recently? ☐ Yes ☐ No

If yes, when and why? ________________________________________________________

____________________________________________________________________________

Have you received Chiropractic care before? ☐ Yes ☐ No If so, when? ____________________

What health goals do you want to achieve in general as well as through Chiropractic care?

____________________________________________________________________________

____________________________________________________________________________

**PLEASE LEAVE NO FIELDS BLANK**

Are you experiencing and additional symptoms? Please mark all that apply.

- ☐ headaches
- ☐ neck stiffness
- ☐ neck pain
- ☐ mid-back pain
- ☐ low back pain
- ☐ difficulty sleeping
- ☐ fatigue
- ☐ nervousness / anxiety
- ☐ irritability
- ☐ tension
- ☐ flushed face
- ☐ dizziness
- ☐ ringing ears
- ☐ fainting
- ☐ fever
- ☐ hot flashes
- ☐ irregular menstruation
- ☐ shortness of breath
- ☐ loss of smell
- ☐ loss of taste
- ☐ numbness in finger/s - hand/s
- ☐ numbness in toe/s - feet
- ☐ foot / heel pain
- ☐ frequent urination
- ☐ "pins & needles" in arms
- ☐ "pins & needles" in legs
- ☐ loss of balance
- ☐ cold hands / feet
- ☐ cold sweats
- ☐ constipation
- ☐ diarrhea
- ☐ upset stomach
- ☐ loss of memory
- ☐ depression
- ☐ unexplained weight loss

other: ______________________
______________________________

List any and all auto collisions in your personal history. (Please note the year, severity, and outcomes.)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

What medications, vitamins / herbs are you taking? ______________________________________
______________________________________________________________________
______________________________________________________________________

Do you smoke? ☐ Yes ☐ No If yes, ________ pack(s) per day for __________ years.

Do you drink alcohol? ☐ Yes ☐ No If yes, (number) _______ drinks of ________________ per week.

Please list all history of surgeries: ______________________________________________
______________________________________________________________________
______________________________________________________________________

Do you have a family history of: (mark all that apply)

☐ Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other: ______________________________

**PLEASE LEAVE NO FIELDS BLANK**

**I certify that to the best of my knowledge the above information is complete and accurate. I understand that I am responsible for all charges and services rendered and I agree to notify this office immediately whenever I have changes in my health condition.**

______________________________________________________________________

**signature** **print name** **date**

# Patient's Informed Consent to Chiropractic Care

When a patient seeks Chiropractic care and when a Chiropractor accepts a patient for such care, it is essential that they both be seeking and working toward the same goals.

Chiropractic has only one goal. It is, therefore, important that the patient understands the goal and the means that will be used to attain it. In this way, there will be no confusion, misunderstanding, or disappointment.

Patients usually want to get rid of whatever ailments or conditions are bothering them. This, however, is **NOT** the goal of the Chiropractor. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

The purpose of Chiropractic care is to restore and maintain the mechanical integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine. Tiny misalignments of the vertebrae (bones of the spine), which interfere with the function of these nerve pathways are called subluxations. Subluxations come from many causes and prevent various organs, glands, muscles, and other tissues from working properly.

By means of a Chiropractic adjustment, subluxations are corrected, thus establishing more normal nerve function. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. The goal of Chiropractic care is to correct vertebral subluxations for the purpose of restoring the proper transmission of nerve energy over nerve pathways so that every part of the body may have a proper nerve supply at all times. This removes a major interference to the innate healing ability of the body.

With an improved nerve supply, health improves. In some, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not at all. This office nor does the Chiropractor engage in the medical practice of diagnosis and treatment of disease. Regardless of what the disease is called, the Chiropractor does not offer to diagnose, heal, or treat it. Nor does he offer advice regarding the treatment of disease. His only goal is to remove an interference to the bodies natural functioning. His only means is the correction of vertebral subluxation. He promises no cure from and offers no treatment of disease.

It has been explained to the patient (or the guardian of the patient), care will include physical examination with pressure applied to the neck, back, and pelvis if deemed necessary by the Chiropractor as well as diagnostic x-ray if deemed necessary.

I have had an opportunity to discuss the care with the doctor of Chiropractic and maintain the right to ask any future questions that arise during care, in regard to care.

It has been explained that in rare instances complications are possible following Chiropractic adjustments. Such complications include but are not limited to: fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, injury to intervertebral disks, nerves or spinal cord, or stroke. In most cases of complication, the severity of Chiropractic adjustment is limited headache and/or soreness or stiffness of joints and/or muscles.

I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, in the best interest of proper Chiropractic care. If during the course of care a non-Chiropractic or unusual finding is encountered, you will be advised of the findings and recommend to seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of Chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept Chiropractic care on this basis.

| signature | print name | date |
|---|---|---|

## Consent to Evaluate and Adjust a Minor

Being the parent or legal guardian of a minor who is to receive Chiropractic care in this office, I have read and fully understand the above terms of acceptance and hereby grant permission for a minor under my legal guardianship to receive Chiropractic care and to be adjusted using Chiropractic methods.

**print child's name**

| signature | print name | date |
|---|---|---|

**To be completed by patient or by patient's representative, if necessary, e.g., if patient is physically or legally incapacitated: (if applicable)**

| signature | print name | date |
|---|---|---|

# Conway Family Chiropractic Health Center LLC
# Health-Related Information Privacy Policy

Caregivers, such as nurses, doctors, therapists, nutritionists and social workers may use an individual's health information to determine current plan of care. Employees and programs within Conway Family Chiropractic Health Center LLC (to be referred to Agency, or the Agency, henceforth) may share health information about an individual in order to coordinate the services he/she may need, such as Chiropractic care, clinical examinations, therapy, nutritional services, medications, hospitalization or follow-up care. Agencies may also use an individual's health information to determine if his/her Chiropractic care is necessary or to ensure that proper healthcare is being given.

Agencies may share an individual's information, when appropriate, with other government programs such as Workers' Compensation, Medicaid, Medicare in order to coordinate his/her benefits and payments. Agencies may also tell an individual's health plan he/she is going to receive in order to obtain prior approval or to determine whether his/her plan will cover the care which is to be provided.

The Agency may use and release information about an individual to ensure that the services and benefits provided to him/her are appropriate and are high quality. Agencies may combine health information about many individuals to research health trends, to determine what services and programs should be offered, or whether new methods or services are useful. Agencies may share an individual's health information with business partners who perform functions on behalf of the Agency.

Agencies may release an individual's health information to other government agencies that are providing an individual with benefits or services when the information is necessary for him/her to receive those benefits and services.

The Agency may contact an individual about reminders for Chiropractic care, or health check-ups. The Agency may also contact an individual to tell him/her about health related benefits or services that may be of interest to him/her or to give the individual information about his/her managed care choices.

The Agency may release an individual's health information to other divisions within the Agency as it relates to public health, subject to the provisions of applicable State and Federal law, for the following kinds of activities:

> To prevent or control disease, injury or disability or to keep vital statistics records such as births and deaths;
>
> To notify social service agencies that are authorized by law to receive reports of abuse, neglect or domestic violence;
>
> To report reactions to medications or problems with products to the Food and Drug Administration (FDA).

The Agency may share an individual's health information with other divisions within the agency and with other agencies for oversight activities as required by law.

The Agency may release health information to a law enforcement official, subject to applicable Federal and State law and regulations, for purposes that are required by law or in response to a court order or subpoena.

The Agency may release an individual's health information for research projects that have been reviewed and approved by an institutional review board or privacy board to ensure the continued privacy and protection of the health information.

If an individual is involved in a lawsuit or a dispute, the Agency may release health information about him/her in response to a court or administrative order. The Agency may also release health information about an individual in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell the individual about the request or to obtain an order protecting the information requested.

The Agency may release health information to a coroner, medical examiner or funeral director, as necessary to carry out duties as authorized by law.

The Agency may release an individual's health information if it is necessary to prevent a serious threat to his/her health and safety or to the health and safety of the public or another person.

The Agency may release an individual's health information to an authorized Federal official or other authorized persons for purposes of national security, for providing protection to the President, or to conduct special investigations, as authorized by law.

If an individual is an inmate of a correctional institution or under the custody of a law enforcement officer, the Agency may release his/her health information to the correctional institution or law enforcement officer. The information released must be necessary for the institution to provide an individual with health care, protect his/her health and safety or the health and safety of others, or for the safety and security of the correctional institution.

If an individual is a veteran or a current member of the armed forces, the Agency may release his/her health information as required by military command or veteran administration authorities.

**If an individual does not object and the situation is not an emergency and disclosure is not otherwise prohibited by stricter laws, the Agency is permitted to release his/her information under the following circumstances:**

The Agency may release an individual's health information to a family member, other relative, friend or other person whom the individual has identified to be involved in his/her health care or the payment of his/her health care.

The Agency may use an individual's information to notify a family member, a personal representative or a person responsible for his/her care, of his/her location, general condition or death. The Agency may release an individual's health information to an agency authorized by law to assist in disaster relief efforts.

The Agency is required by State and Federal law to maintain the privacy of an individual's health information. Agencies are required to give an individual this notice of its legal duties and privacy practices with respect to the health information that the Agency collects and maintains about the individual. Agencies are required to follow the terms of this notice.

This notice describes and gives some examples of the permitted ways that an individual's health information may be used or released. Release of an individual's information outside of the boundaries of Agency-related provided care, payment or operations, or as otherwise permitted by State or Federal law, will be made only with an individual's specific written authorization. An individual may revoke specific authorizations to release his/her information, in writing, at any time. If an individual revokes an authorization, the agency will no longer release the individual's health information to the authorized recipient(s), except to the extent that the Agency has already used or released that information in reliance of the original authorization.

Individuals have the following rights regarding the health information that the Agency has about him/her:

Individuals have the right to inspect and obtain a copy of their health information. It does not include information that is needed for civil, criminal or administrative actions or proceedings or psychotherapy notes. Agencies may charge a fee for the costs of copying, mailing or other supplies associated with an individual's request.

If an individual feels that the health information the Agency has created about him/her is incorrect or incomplete, he/she may ask for the information to be amended.The Agency may deny the request if an individual asks to amend information that: 1) was not created by the Agency; 2) is not part of the health information kept by the Agency; 3) is not part of the information which the individual would be permitted to inspect or copy; or 4) the information is determined to be accurate and complete.

Individuals have the right to request a list of information releases that the Agency has made of their health information. The list will not include: 1) health information releases made for purposes of providing heath care to an individual, obtaining payment for services or releases made for administrative or operational purposes; 2) health information releases made for national security; 3) health information releases made to correctional institutions and other law enforcement custodial situations; 4) health information releases the Agency has made based on an individual's written authorization; 5) health information releases to persons who are involved in an individual's care; or 6) health information releases made prior to April 16, 2003.

Individuals have the right to request a restriction or limitation of the health care information the Agency uses or releases for treatment, payment or operational purposes. The Agency is not legally required to agree the requested restriction or limitation.

Individuals have the right to request that Agencies communicate with them about health care matters in a certain way or at a certain location. For example, an individual can request that the Agency only contact him/her at work or by email. The Agency will accommodate all reasonable requests. To request confidential communications, an individual must specify how or where he/she wishes to be contacted.

Individuals have the right to request a paper copy of this notice from this Agency at any time.

**All requests for inspecting, copying, amending, making restrictions, or obtaining an accounting of an individual's health information must be made in writing to:**

**Conway Family Chiropractic Health Center LLC**
**2221 Washington Avenue**
**Conway, AR 72032**
**501.205.8201**

If an individual believes his/her privacy rights have been violated,

> To file a complaint to the Conway Family Chiropractic Health Center LLC, contact: Dr. Joseph Morrison DC
> An individual may file a complaint with the Arkansas HIPAA contact: Office of the Executive CIO; 124 West Capitol, Suite 200; Little Rock, AR 72201; 501-682-4301.
> An individual may file a complaint with the facility or with the Secretary of the Department of Health and Human Services. You may call them at 877-696-6775 or write to them at 200 Independence Ave. S.W., Washington, DC, 20201.
> An individual may file a grievance with the Office of Civil Rights by calling 866-OCR-PRIV (866-627-7748), or 886-788-4989 TTY.

Agency reserves the right to revise this policy and make the revised policy effective for the health information it already has about an individual, as well as any information it creates or receives in the future. The Agency will provide individuals with a copy of the revised policy within 60 days. The Agency will post a copy of the current policy at its website. In addition, an individual may ask for a copy of his/her Agency's current policy regarding privacy practices anytime an individual visit to an Agency facility for health care services.

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By my signature below, I hereby acknowledge that I have received and reviewed this Privacy Policy.

| **signature** | **print name** | **date** |
|---|---|---|