Family Chiropractic Care New Patient Information Worksheet*

Name:_____ **SSN:**_____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Hm: _____ **Wk:** _____ **Date of Birth:**_____

E-Mail _____**Employer**: _____ **Insurance:** _____

Policy/I.D. # : _____**Spouses Name**:_____

Marital Status: S M D W # of Children _____ **Spouses D.O.B.:** _____ **Spouses SSN:** _____

Family Dr. : _____ **Family Lawyer:** _____

Referred By: (Friend) (Relative) (Newspaper Ad) (Yellow Pages) (Sign) (Other: _____)

Which one of our patients should we thank for referring you ? _____

Please circle your current symptoms: (Headaches) (Neck Pain) (Neck Stiffness) (Shoulder/Arm Pain/Numbness) (Mid Back Pain) Chest Pain) (Low Back pain) (Hip/Pelvis Pain) (Leg Pain/Numbness) (Dizziness) (Allergies) (Asthma) (Sinus Problems) (Stomach/Bowel Pain) (Menstrual Problems) (Arthritis) (Ear Infection) (Stress) (Depression) (Cold Hands/Feet) (Diabetes) (Cancer) (Other: _____)

My symptoms are due to: (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset) (Other:_____

List all surgeries in the past 5 years: _____

List Present medications: _____

Have you ever had spinal surgery? (No) (Yes) (Neck) (Low Back) **When:** _____

List any serious condition that the doctor should be aware of: _____

Previous Chiropractor: _____ **Were you satisfied?:** (No) (Yes)

*** Females: Are you pregnant at this time?** (No) (Yes) **Due Date:** _____

Office Policies: *If I am accepted as a patient at Family Chiropractic Care, I agree to pay for all services not covered by the insurance company. If I suspend or terminate my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I understand that no medical records or X-rays will be released from this office without my written consent, and payment of copying and postage.*

Consent to Treat: *I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Montagne to proceed with any necessary treatment. I have read Dr. Montagne's office policies and consent to treatment by signing below:*

Referral: If we do a really great job, will you promise to refer someone else to us?

Signature: _____ **Date:** _____

Parent/ Guardian Signature: _____ **Date:** _____

Family Chiropractic Care* Health Worksheet

Please list the 5 main health concerns that you would like us to address today.

1. _____
_____
_____
2. _____
_____
_____
3. _____
_____
_____
4. _____
_____
_____
5. _____
_____
_____

On the other side is a timeline. Please place any significant health events that occurred to you, your mother, and your grandmother on the timeline. Health events are things like illness, hospital stays, surgeries, traumas, abuse, or just plain not feeling well.

Birth

Today

Family Chiropractic Care

Your Accident and Injury Center

Dr. Brad J. Montagne

501 N Arrowhead Lane, PO Box 649

Moose Lake, MN 55767

Ph/Fax (218) 485-4451

Patient's Name **Date:**

*[Please **circle the number** which most closely describes your chief complaints) today:*

1. Pain Intensity

(0)	(1)	(2)	• — (3)	(4)
No Pain	Mild Pain	Moderate Pain	SeverePaia	Worst Possible Pain

2. Frequency Of Pain

No Pain	Occasional Pain 25% Of The Day	Intermittent Pain 50% Of The Day	Frequent Pain 75% Of The Day	Constant Pain 100% Of The Day

3. Personal Care (Washing, Dressing, etc.)

(0)	(1)	(2)		**(4)**
No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need some assistance	Severe Pain Need 100% Assistance

4. Travel (Driving, Riding, etc.)

(2) (3) (4)

No Pain Long Tnps	Mild Pain On On Long Trips	Moderate Pain On Long Trips	Mode rate Pain On Short Trips	Severe Pain On Short Trips

5. Work

(0")-..

(1) (2) (3) (4)

Can Do Usual Work Plus Extra Work	Can Do Usual Work No Extra Work	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work

6 Recreation

(0) (1) (2) (3) (4)

Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities

7. Sleeping

(0) (1) (2) (3) (4)

Perfect Sleep	Mildly Disturbed	Moderate! y Disturbed	Greatly Disturbed	Totally Disturbed

8. Lifting

(0) (1) (2) (3) (4)

No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With My Weight

9. Walking

(0) (1) (2)v**B*******B (3) (4)

No Pain Any distance	Increased Pain After One Mile	Increased Pain After Half Mile	Increased Pain After Quarter Mile	Increased Pain With All Walking

10. Standing

(0).	(1)	(2)	--•(3)	(4)
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After One Hour	Increased Pain After Half Hour	Increased Pain With Any Standing

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Patient Health History Worksheet

Patient's Name: Date:

Present Health History

When did your present condition begin?
a) Gradual Onset (no specific date)
b) Date: _____

What caused your present condition? a) No specific injury -b) Home accident
c) Work Accident
d) Auto Accident,

What happened to cause your present pain?
_____
_____
_____
_____
_____
_____

Have you ever had these symptoms before?
a) No
b) Yes: (Date: _)

What time of day are your symptoms **better?**
a) Morning
b) Afternoon
c) Evening
d) None of the above (constant pain)

What time of day are your symptoms worse?
a) Morning
b) Afternoon
c) Evening
d) Ail of the above (constant pain)

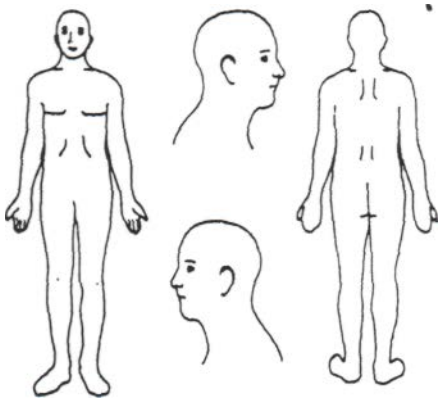
Have you missed any work from this condition?
a) No
b) Yes: (Date_____)

What makes your pain better?
a) Rest
b) Ice packs/Heating pads
c) Prescription Medications
d) Drug store medications (Ibuprofen, Advil)
e) Other:_____

What makes your pain worse?
a) Activity (work, repetitive motions)
b) Ice packs/Heating pads
d) Driving (or riding) in car
e) Other:_____

What home remedies have you tried?
a) Ice packs
b) Heating pads/Hot tubs
c) Exercise
d) Other: _____

Please Label The Area(s) Of Today's Pain



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Patient Health History Worksheet

Patient's Name: Date:

Significant Past Health History

Have you ever been hospitalized?
a) No
b) Yes: (Year:_____) (Reason:_____

Have you had any surgeries?
a) No
b) Yes: (Year:_____) (Reason:,

Do you have any significant health problems?
a) No
b) Yes: (_____)

Significant Past Medical History

Have you seen another doctor for this condition?
a) No
b) Yes: (Name:_____)

Did this doctor recommend any treatment?
a) No
b) Yes: (_____)

Are you taking any medications?
a) No
b) Yes: (_____)

Significant Past Social History

Do you play any sports or exercise?
a) No
b) Yes: (_____

How many hours do you sleep a night? (_____)

How many hours a week do you work? (_____)

Significant Family Medical History

Did your father have any health problems?
a) No
b) Yes: (_____)

Did your mother have any health problems?
a) No
b) Yes: (_____)

Did your brother(s) have any health problems?
a) No
b) Yes: (_____)

Did your sister(s) have any health problems?
a) No
b) Yes: (_____)

Did your grandpa have any health problems?
a) No
b) Yes: (_____)

Did your grandma have any health problems?
a) **No**
b) **Yes:** (_____)

Health Risk Factors

Do you drink alcohol?
a) No
b) Yes: (
_____
;

Do you smoke?
a) No
b) Yes: (_____

Anything else the doctor should know about?
a) No b.) Yes: _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

1 consent to the use or disclosure of my protected health information by **Family Chiropractic Care** for purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of by **Family Chiropractic Care** I understand diagnosis or treatment of me by **Dr. Brad J. Montagne** may be conditioned upon my consent as evidenced by my signature on this document.

*****I understand that not all chiropractic services are covered by my health care insurance, I understand that I am responsible for payment of these services regardless of the contract between Family Chiropractic Care, Dr. Brad Montagne, and my insurance company.**

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of this practice. By **Family Chiropractic Care** is not required to agree to the restrictions that I may request. However, if by **Family Chiropractic Care** agrees to a restriction I request, the restriction is binding on by **Family Chiropractic Care** and **Dr. Brad Montagne.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Brad J. Montagne** or by **Family Chiropractic Care** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer.or a health care or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I do not give my consent to have my health information placed on any electronic media that allows anyone outside of this facility to view it.

I understand I have the right to review by **Family Chiropractic Care's** Notice of Privacy Practices prior to signing this document. The **Family Chiropractic Care's** Notice of Privacy Practices has been provided to me The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of by **Family Chiropractic Care** The notice of Privacy Practices for by **Family Chiropratic Care** is also provided at 501 N **Arrowhead Lane, Moose Lake** MN. The Notice of Privacy Practices also describes my rights and the by **Family Chiropractic Care's** duties with respect to my private health information.

By **Family Chiropractic Care** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of the next appointment.

_____ Date: _____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

FAMILY CHIROPRACTIC CARE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU **MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.PLEASE REVIEW THIS NOTICE CAREFULLY.**

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice.

CONSENT

1. The Practice may use and/or disclose your PHI provided that it first obtains a valid Consent signed by you. The Consent will allow the Practice to use and/or disclose your PHI for the purposes of:

(a) Treatment

(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements

(c) Health Care Operations

NO CONSENT REQUIRED

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following instances:

(a) De-identified Information-Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate -A business associate is an entity that assists the Practice in undertaking some essential function, such as. a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers -*If*, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances,

(f) Public Health .

(g) Abuse, Neglect or Domestic Violence • To a government authority if the Practice is required by law to make such disclosure

(h) Health Oversight Activities

(i) Avert a Threat to Health or Safety

0') Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice'may be required to disclose your PHI to an individual or entity

' that is part of the. Workers' Compensation system.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice:

a) a postcard mailed to you at the'address provided by you; and

b) telephoning your home and leaving a message on your answering machine-or with the individual answering the phone.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time, by a written request to the Practice's Privacy Officer. '

(e) Amend your PHI as provided by law, by a written request.

(f) Receive an accounting of disclosures of your PHI as provided by law

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to.the Practice's Privacy Officer.

(h) Complain to the Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing. (i) To obtain more information on, or have your questions about your rights answered, you may us at (218) 485-4451.

PRACTICE'S REQUIREMENTS

1. The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains,

(e) Will distribute any revised Privacy Notice to you prior to implementation.

Name _____ Signature _____ Date _____

Guardian _____ Signature _____