



Better Health CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

(please print)

Personal:

Date: _____

Full Name: _____

Address: _____

Male/Female Social Security #: _____ - _____ - _____ DL #: _____

Phone #: Home: () _____ Work: () _____

Cell: () _____ E-mail: _____

Marital Status (circle one): **M S W D** Age _____ Birthdate _____

Height: _____ Weight: _____ Pregnant? **Y N** No. of Children: _____

Name of spouse, parent or guardian: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Address: _____

Phone: _____ Relationship: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Employment:

Employer: _____ Occupation: _____

Address: _____

Work Phone #: () _____ ext. _____

Insurance Information:

Policy Holder: _____

Relationship to patient: _____ Insurance Co.: _____

Occupation of Insured: _____ ID# of Insured: _____

Date of birth of Insured: _____ Employer of Insured: _____

Employer Address: _____ Have you met your deductible? **Y N**

Chiropractic History:

Please list the last chiropractor you have seen.

Name of Doctor: _____ Date last seen: _____

Address: _____ Phone #: _____

Consulted for: _____

Surgical History:

Type: _____ Date: _____
Type: _____ Date: _____
Type: _____ Date: _____

Medical History:

Primary Care Physician-
Name of Doctor: _____ Date last seen: _____
Address: _____ Phone #: _____
Consulted for: _____

Accidents and/or Injuries:

Type: _____ Date: _____ Hospitalized? Y N
Type: _____ Date: _____ Hospitalized? Y N
Type: _____ Date: _____ Hospitalized? Y N

Medications: (over the counter AND Prescription)

1. _____ For: _____
2. _____ For: _____
3. _____ For: _____
4. _____ For: _____

Past Health History:

<input type="checkbox"/> Recent Infection	<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> History of Alcohol Abuse
<input type="checkbox"/> Recent Fever	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Abnormal Weight Gain/Loss
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Recent Trauma	<input type="checkbox"/> Birth Control Pills/Shot/Patch
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Corticosteroid Use	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Aortic Aneurysm
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Urinary Retention	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Stroke (date _____)	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> History of Neck Pain
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/> History of Low/Mid Back Pain
<input type="checkbox"/> Numbness in groin/buttocks	<input type="checkbox"/> Depression	<input type="checkbox"/> Headaches

Reason for Consulting this Office:

I have no symptoms, and I feel well. I am interested in continuing and improving my good health.
 I have a specific health problem, complaint, or illness.

List your health problems or complaints according to their severity:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier, and myself. Furthermore, I understand that BETTER HEALTH CHIROPRACTIC may prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to BETTER HEALTH CHIROPRACTIC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

NAME(Please Print): _____ DATE: _____

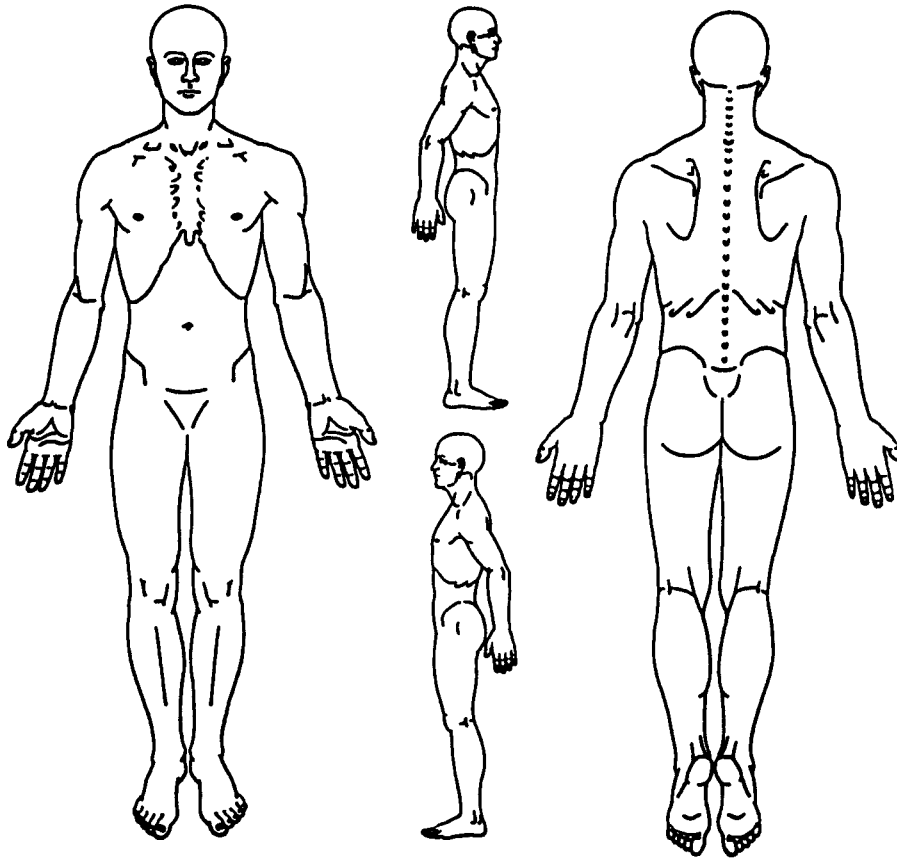
AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

HOW LONG HAVE YOU HAD THIS PAIN? _____ YEARS _____ MONTH _____ WEEKS

IS THIS YOUR FIRST EPISODE OF THIS PAIN? _____ YES _____ NO

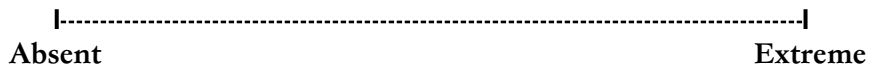
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SENSATIONS RIGHT NOW
(Please remember to complete both sides of this form.)

KEY: A=ACHE B=BURNING N=NUMBNESS
 P=PINS & NEEDLES S=STABBING O=OTHER

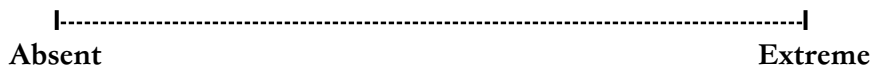


Please rate your pain level by placing an X on the scale below:

Pain level TODAY:



Average Pain level over the PAST WEEK:



GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating *overall* impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, **PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES**. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been disrupted or prevented by your pain.

1. **Family/Home Responsibilities.** This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school.)

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

2. **Recreation.** This category includes hobbies, sports, and other similar leisure time activities.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

3. **Social Activity.** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

4. **Occupation.** This category refers to activities that are part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

5. **Self Care.** This category includes activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.).

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

6. **Life-Support Activity.** This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

TOTAL SCORE: _____

SIGNATURE: _____

DATE: _____

HIPAA HAPPENINGS AT



This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise to You, Our Valued Patient...

We want to assure you that we take the new Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now ?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of electronic technology in the health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review how your information is used within our computers, internet, phones, fax machines, and any device used to copy or transfer that data. We want to advise you that we have developed policies and procedures for our practice to assure that your personal health information will be shared only as required for the purpose of administering your care. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we promise our adherence to those laws. We also want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used To Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories, or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice in order to collect payment for the services provided to you in this office. We may do this with insurance forms filed for you electronically or by mail. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations to our staff. Some of the best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during insurance company audits or by government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you and your family. These communications are an important part of our philosophy, which is to partner with our patients to see they receive the best chiropractic care we can provide. This may include postcards, newsletters, flyers, and telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders).

Public Health and National Security

We may be required to disclose necessary health information to Federal officials or military authorities in order to complete investigations related to public health and or national security.

For Law Enforcement

As permitted or required by State and Federal law, we may disclose your health information under certain circumstances to proper authorities for the purpose of law enforcement. This may take place if you are a victim of a crime, or in order to report a suspected crime.

Family, Friends and Care Givers

We may share your health information with those that assist you with your home hygiene, care, treatment, or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable communicate your wishes, we will use our very best judgement when sharing your health information with anyone participating in your care.

Medical Research

Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories will transpire only under the ethical guidance, requirements, and approval of an Institution Review Board.

Authorization to Use or Disclose Health Information

Other than the information stated above, or information that Federal, State, and Local laws require, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

This law is careful to describe that you have rights related to you health Information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately, with or without other family members present, or through sealed mail communications. We will make all reasonable efforts to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information. This includes your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested, sealed, and/or delivered to any authority for review.

Documentation of Health Information

You have the right to request a description of how our office used your health information for reasons other than treatment, payment, or health care operations. Our documentation procedure will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We greatly appreciate your limited request for no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of This Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. We are required by law to maintain privacy of our health information and provide to you or your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. Patients will be notified of any such changes. You have the right to express concerns or complaints to any staff member of Better Health Chiropractic, or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Patient Acknowledgment

Patient Name(s):

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledgments that you have received, thoroughly reviewed, and understand this policy by signing on the line below. Thank you.

Patient Signature

Date