

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in **ALL** portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have our someone help you.

Your Name: _____ Date: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone #: _____ Pager: _____ Cell Ph: _____

Age: _____ Date of Birth: _____ SS#: _____ E-mail: _____

Marital Status: M S D W Drivers License # _____

Your Occupation: _____ Employed by: _____

Phone #: _____ Address: _____

Is your visit due to an accident? Yes / No Work/ Auto/ Sports/ Other: _____

Your Spouse's Name: _____ Spouse's Employer: _____

Spouse's work phone #: _____ Spouse's cell phone #: _____

Name of person to contact in case of emergency: _____

Their home and work phone numbers: _____

Name of nearest relative not living with you: _____ Their phone #: _____

Who referred you to this office so we may thank them? _____

Referring Physician: _____ Phone #: _____

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient's Signature: _____ Date: _____

Parent or Guardian: _____
Signature: _____ Date: _____

Date: _____

Present Complaints

Chief Complaint: _____

Secondary Complaint: _____

- Difficulty in: Standing, Sitting, Bending, Walking
Pain radiation to the: Right arm, Left arm, Right leg, Left leg
Cannot lift: Light, Moderate, Heavy, Repetitive
Pain radiating to: Neck, Base of skull, Ribs, Shoulders, Arms
Pain in the: Foot, Ankle, Knee, Hip, Heel spurs

What seems to help your problem? _____

Since the time this (these) complaint(s) began, what, if anything, have you tried that **did not** work? _____

Has the problem interrupted your sleep? Yes / No How? _____

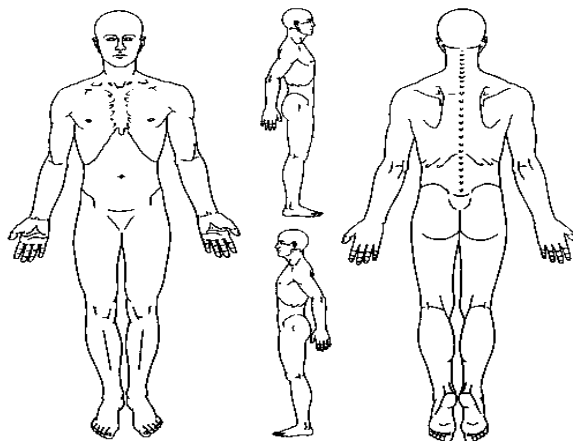
Do you feel fully rested after an average night's sleep? Yes / No – Avg hours of sleep: _____

How high would you rate the average stress levels in your life? Low / Medium / High / Very High

List any doctors or therapists that you have seen for this complaint:

1. _____ Specialty _____
2. _____ Specialty _____
3. _____ Specialty _____

Please indicate the location(s) of discomfort below: (xxx – Pain) (/// - Stabbing)
(bbb- Burning) (www – Weak)
(ooo – Pins) (--- Numb) S=Spasms



IMPORTANT: PLEASE CHECK ALL SYMPTOMS

HEAD:

- Headache
 - Sinus (allergy)
 - Entire head
 - Back of head
 - Forehead
 - Temples
 - Migraine
- Head feels heavy
- Loss of memory
- Light-headedness
- Fainting
- Light bothers eyes
- Blurred vision
- Double Vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Bussing in ears

NECK:

- Pain in neck
- Neck pain with movement
 - Forward
 - Backward
 - Turn to left
 - Turn to right
 - Bend to left
 - Bend to right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

SHOULDERS:

- Pain in shoulder joint (R-L)
- Pain across shoulders
- Bursitis (R-L)
- Arthritis (R-L)
- Can't raise arm
 - above shoulder level
 - over head
- Tension in shoulders
- Pinched nerve in shoulder (R-L)
- Muscle spasms in shoulders

ARMS & HANDS:

- Pain in upper arm
- Pain in elbow
- Movement aggravated
- Tennis elbow
- Pain in forearm
- Pain in hands
- Pain in fingers
- Sensation of pins/needles in arms Sensation of pins/needles in fingers
- Numbness in arms (R-L)
- Numbness in fingers (R-L)
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Sore joints in fingers
- Arthritis in fingers
- Loss of grip strength

MID-BACK:

- Mid-back pain
- Location _____
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Pain from front to back
- Muscle spasms
- Pain in kidney area

CHEST:

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange peel breast
- Irregular heartbeat

ABDOMEN:

- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:

- Low back pain
 - Upper lumbar
 - Lower lumbar
 - Sacroiliac
- Low back pain is worse when:
 - Working
 - Lifting
 - Stooping
 - Standing
 - Sitting
 - Bending
 - Coughing
 - Lying down (sleeping)
 - Walking
- Pain is relieved when _____
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

HIPS, LEGS & FEET:

- Pain in buttocks (R-L)
- Pain in hip point (R-L)
- Pain down leg (R-L)
- Pain down both legs
- Knee pain
 - Inside
 - Outside
- Leg cramps
- Cramps in feet (R-L)
- Pins/needles in legs (R-L)
- Numbness of leg (R-L)
- Numbness of feet (R-L)
- Numbness of toes (R-L)
- Feet feel cold
- Swollen ankles (R-L)
- Swollen feet (R-L)

MEN ONLY:

- Urinary frequency
- Difficulty in starting
- Night urination
- Prostate pain/swelling

WOMEN ONLY:

- Menstrual pain _____ (where)
- Cramping
- Irregularity
- Cycle _____ (days)
- Birth control _____ (type)
- Hysterectomy
- Genital cancer _____ (type)
- Discharge
- Menopause _____
- Tumors
- Abortions
- Are you or do you think you might be pregnant?

GENERAL:

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run-down
- Normal sleep _____
- Loss of sleep _____ hrs/night
- Loss of weight _____ lbs.
- Gain weight _____ lbs.
- Coffee _____ cups/day
- Tea _____ cups/day
- Cigarettes _____ pack/day
- Other _____
- Diabetes
- Hypoglycemia

MEDICAL HISTORY:

(If any of the following are relevant to your medical history, please check the accompanying box)

- Muscle Dystrophy
- Rheumatic Fever
- Digestive Disorders
- Multiple Sclerosis
- Sinus Trouble
- Convulsions
- Backaches
- German Measles
- Heart Trouble
- Dizziness
- Diabetes
- High Blood Pressure
- Venereal Disease
- Pins/needles in legs (R-L)
- Numbness of leg (R-L)
- Numbness of feet (R-L)
- Numbness of toes
- Feet feel cold
- Swollen ankles (R-L)
- Nervousness
- Swollen feet (R-L)
- Cancer
- Asthma
- Polio
- Epilepsy
- Numbness
- Concussion
- Scarlet Fever
- Arthritis
- Tuberculosis
- Hepatitis

History / Lifestyle

List any operations that you've had and approximate dates:

1. _____ Date: _____ Dr: _____
2. _____ Date: _____ Dr: _____
3. _____ Date: _____ Dr: _____
4. _____ Date: _____ Dr: _____

Are you allergic to any medication? Please list:

Are you taking any medications? Please list: _____

On a scale of 0-10, 0 being no pain at all and 10 being the worst possible pain imaginable, what would you rate each of your conditions? _____

Are you pregnant? Yes / No Due date: _____

of Pregnancies: _____ # of Deliveries: _____ # of Miscarriages: _____

Do you: Smoke: Yes / No Amount per day: _____

Drink: Yes / No Light Medium Heavy

Exercise: Never Sometimes Frequently Regularly

Type of exercise: _____ Sports injuries: _____

Spicy Food: Never Sometimes Frequently Regularly – Avg # Meals/day: _____

Aversion to: (circle) wind / heat / cold / damp / dryness - Allergies: _____

Fatigue after meals? Yes / No - Gas after meals? Yes / No – Binge Eating? Yes / No

Does anyone in your family have a similar health related problem? Yes / No

Who?: _____ What condition?: _____

Care they are receiving: _____

Is there anything else you would like us to know? _____

(continue on back if necessary) _____

Patient Name: _____ **Date:** _____

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practices is _____.

Thank you.

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to (*insert name of practice*) to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (*insert phone number*). You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

X _____
Print Patient's Name

X _____
Patient's Signature

X _____
Other Than Patient, Print Name & Relationship

X _____
Witness