

*** Complete Health Chiropractic * New Patient Information Worksheet ***

Name: _____ Age: _____ Birth Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employed By: _____ Insurance Provider: _____

Subscriber Name: _____ Subscriber Birth Date: _____

Primary Care Physician: _____ Social Security #: _____ - _____ - _____

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

Please circle your current symptoms:

(Headaches) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain) (Upper-Back Pain)

(Mid-Back Pain) (Low-Back Pain) (Hip/Pelvis Pain) (Sinus Problems) (Asthma) (Stomach Pain) (Chest

Pain) (Numbness) (Arthritis) (Sciatica) (Stress) (Other): _____

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

List all surgeries in the past five years: _____

Have you ever had spinal surgery? (No) (Yes): _____

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

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

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

Date of Last Menstrual Period: _____

Office Policies: *If I am accepted as a patient to Dr. Meyer's Chiropractic Office I agree to pay for all services, including services not covered by my 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 then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.*

Consent for X-Ray (If needed): *I authorize Dr. Robert Meyer, D.C. to do an X-Ray examination if needed. I also hereby state that I am not pregnant at this time.*

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. Meyer to proceed with any necessary treatment. I have read Dr. Meyer's office policies and consent to treat information, and I agree with them by signing below:*

Privacy Practices Acknowledgement: *I have received the Notice of Privacy Practices and I have been provided an opportunity to review it*

Signature: _____ **Date:** _____

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

Complete Health Chiropractic Office

Dr. Meyer Ph: (817) 310-6604

100 W. Southlake Blvd., Suite #410

Southlake, TX 76092

Patient's Name: _____ Date: _____

Please circle the number that most clearly describes your chief complaint(s) today:

1. Pain Intensity

0 ----- 3 ----- 5 ----- 7 ----- 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

2. Frequency of Pain

0 ----- 3 ----- 5 ----- 7 ----- 10
No Pain Occasional Intermittent Frequent Constant

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

0 ----- 3 ----- 5 ----- 7 ----- 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

4. Travel (Driving, Riding, etc.)

0 ----- 3 ----- 5 ----- 7 ----- 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

5. Work

0 ----- 3 ----- 5 ----- 7 ----- 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

6. Recreation

0 ----- 3 ----- 5 ----- 7 ----- 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

7. Sleeping

0 ----- 3 ----- 5 ----- 7 ----- 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

8. Lifting

0 ----- 3 ----- 5 ----- 7 ----- 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

9. Walking

0 ----- 3 ----- 5 ----- 7 ----- 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

10. Standing

0 ----- 3 ----- 5 ----- 7 ----- 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

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100 W. Southlake Blvd #410

Southlake, TX 76092

Patient Health History Worksheet

Patient's Name: _____ **Date:** _____

Present Health History

When did your present symptoms begin?

- a) Gradual Onset (no specific date)
- b) Date: _____

What caused your pain?

- a) No specific injury
- b) Home accident
- c) Work accident
- d) Auto accident

If the injury was caused by an accident, please describe.

Have you ever had these symptoms before the injury listed above?

- a) No
- b) Yes: Date: _____

What time of day are your symptoms **better**?

- a) Morning
- b) Afternoon
- c) Evening
- d) All of the above (constant pain)

Have you missed any work from this condition?

- a) No
- b) Yes: Date: _____

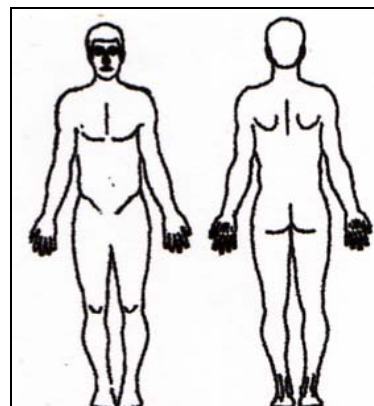
What makes your pain **better**?

- a) Rest
- b) Ice packs/Heating pads
- c) Prescriptions Medications
- d) Drug store medications (Ibuprofen, Advil)
- e) Other: _____

What makes your pain **worse**?

- a) Activity (work, repetitive motions)
- b) Ice packs/Heating pads
- c) Exercise
- d) Other: _____

Please label the area(s) of today's pain:



Complete Health Chiropractic

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

In the course of your care as a patient at Complete Health Chiropractic we may use or disclose personal and health related information about you in the following ways:

- *Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- * Your health care records as well as your billing records may be disclosed to another party, such as insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- *Your name, address, phone number, and your health care records may be used to contact you regarding scheduling related matters, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- *If we are providing health care services to you based on the orders of another health care provider.
- *If we provide health care services to you in an emergency.
- *If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- *If there are substantial barrier to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- *If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein.

We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Donald R. Acton, DC, FICA at 828-258-0264.

This office utilizes an “open-adjusting” environment for ongoing patient care. “Open-adjusting” involves several patients being seen in the same adjusting area at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or discussing financial matters. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. This office also keeps records in non-locked cabinets and sometimes x-ray files are seen in open areas.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open-adjusting” environment are incidental matters, in the event you or someone else would not agree with us, we are providing this disclosure.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed Please) Signature Date

If you are minor, or if you are being represented by another party

Personal Representative Printed Personal Representative Signature Date

Description of the authority to act on behalf of the patient