Last Name: _____ **Date of Birth:** _____

BLACKMAN CHIROPRACTIC CENTER

812 Central Avenue Dover, NH 03801
Ph: (603)742-5881 Fax: (603) 742-6613

Confidential Patient Health Record

***Today's Date*:____/____/_____**

How did you hear about us? ☐ **Family** _____ ☐ **Friend** _____ ☐ **Co-Worker** _____
☐ **Close to home/work** ☐ **Dr.** _____ ☐ **Yellow pages** ☐ **Drove by** ☐ **Website** ☐ **Insurance Plan**

Personal Information

Last:_____ **First:**_____ **Middle:** _____

Birth Date: ____ /____/_____ **Age:**_____ **Sex: Male / Female** **Social Security #:** _____-_____-_____

Address: _____**Apt #** _____

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

Home Phone: (_____) _____-_____ **ext** _____ **Work Phone:** (_____) _____-_____ **ext** _____

Cell Phone: (_____) _____-_____ **ext** _____ **Where should we contact you first: Home Cell Work**

May we leave a message for you at: Home Cell Work

Email Address: _____ **(we will not share your email with any third parties)**

Spouse Name:_____ **Children (Names &Ages):** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Favorite Hobbies/Interests: _____

Primary Care Physician/Phone Number: _____

In case of an Emergency contact:

Last:_____ **First:**_____ **Middle:** _____

Email Address: _____ **Home Phone:** (_____) _____-_____

Cell Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____ **ext** _____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Employment Information

Occupation/Job Title: _____ **Job Description** _____

Business Name/Address: _____

Phone: (_____) _____-_____ **Employer's Email Address:** _____

Accident Information

Is your condition due to an accident: ☐ **No** ☐ **Yes Date:** ____/____/_____ **Time:**____:____ **am/pm**

Type of Accident: ☐ **Auto** ☐ **Work** ☐ **Home** ☐ **Other**

To whom have you made a report of your accident: ☐ **Auto Insurance** ☐ **Employer** ☐ **Workers Comp** ☐ **Other**

Attorney Name (if applicable):_____

Last Name: _____ **Date of Birth:** _____

Current Health Condition

Unwanted Condition (Why you are here today?):_____

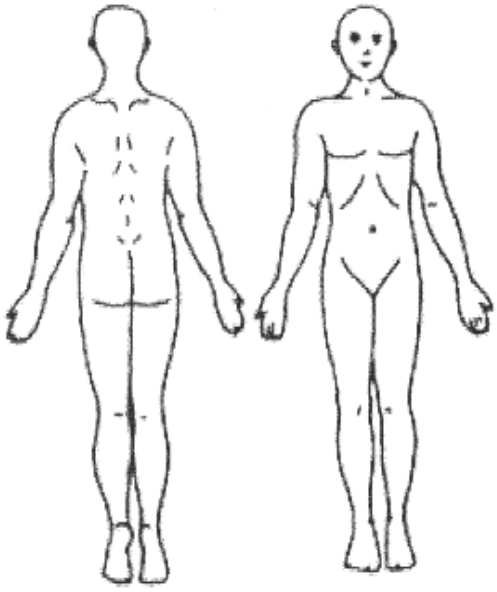
_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

Key: A=Ache B=Burning N = Numbness R=Radiation P=Pins & Needles S=Stabbing D=Dull

→ → → → → → →



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ☐ **Yes** ☐ **No. When?** _____

☐ **Slip or Fall** ☐ **Lifting** ☐ **Slept Wrong** ☐ **Unknown Cause** ☐ **Other**

Explain: _____

_____

Is this condition getting worse: ☐ **Yes** ☐ **No** ☐ **Same**

Current Complaint:(how you feel today)

0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable Pain**

How often are your symptoms present:
(Intermittent) ☐ **0-25%** ☐ **26-50%** ☐ **51-75%** ☐ **76-100% Constant**

In the past week, how much has your pain interfered with you daily activities (e.g, work, social activities, household chores, recreation)?

0 1 2 3 4 5 6 7 8 9 10

No Interference **Unable to Carry on Activities**

1) Change in Bodily Functions: ☐ **Yes** ☐ **No**

☐ **Balance** ☐ **Behavior** ☐ **Bowel Habits** ☐ **Breathing** ☐ **Coordination** ☐ **Coughing** ☐ **Fever**
☐ **Gait** ☐ **Grip** ☐ **Hearing** ☐ **Menstruation** ☐ **Night Sweats** ☐ **Sexual** ☐ **Sleep**
☐ **Sneezing** ☐ **Urination** ☐ **Vision** ☐ **Weakness** ☐ **Weight**

2) Handedness: ☐ **Right** ☐ **Left** ☐ **Ambidextrous**

3) Change in Activities of Daily Living: ☐ **Yes** ☐ **No**

What are you unable to do because of this problem:
☐ **Forgotten with Activity** ☐ **Interferes with Activities** ☐ **Activity Continues Despite Problem**
☐ **Unable to perform Activity** ☐ **Prevents Activity**

4) Work Status: Number of Jobs: 1 2 3

☐ **Full-Time** ☐ **Part-Time** ☐ **Homemaker** ☐ **Student** ☐ **Retired** ☐ **Disabled** ☐**Unemployed** **Shift 1 2 3**

5) Work/Home Disability: ☐ **Yes** ☐ **No**

Complete: _____ **Days off work** **Physical Demands:** ☐ **Heavy** ☐ **Moderate** ☐ **Mild** ☐ **Sedentary**
_____ **Days unable to perform household tasks**
Partial: _____ **Days of job modification** **Stress Level:** ☐ **High** ☐ **Medium** ☐ **Low**
_____ **Days of decreased household chores**

Last Name: _____ Date of Birth: _____

6) Store Bought/Home Remedies: □ Yes □ No
Care not recommended by a doctor.
Type/Effect:
_____
_____

7) Have you seen other Doctors/Practitioners for this condition: □ Yes □ No
Name: _____ Type of Treatment:_____
Were you satisfied with the results: □ Yes □ No
Explain:
_____
_____

8) Have you had any spinal X-rays, MRI, CT Scan for your area(s) of complaint: □ Yes □ No
Date taken:_____ Location: _____ Regions of Body: _____

***9)Previous Chiropractic Care:* □ I have not previously seen a Chiropractor OR Fill in the information BELOW.**
Doctor's Name: _____ Location: _____ Date of Last Visit: _____
Were you satisfied with your care? □ Yes □ No. Why? _____
Do you wear any of the following? □ Heel Lifts □ Innersoles □ Arch Supports □ Orthotics □ Other_____
For how long? _____ Were they prescribed by a doctor? □ Yes or □ No

10) List any disease which you have had in the past, including childhood diseases: _____

11) Tell us if you have ever been diagnosed as having a particular condition such as Diabetes, Cancer, AIDS,etc:_____
_____

12) Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, laceration, sprains, strains, broken or cracked bones? □ Yes □ No
Explain: _____

13) List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth)
_____ Date: ____/____/_____
_____ Date: ____/____/_____
_____ Date: ____/____/_____
_____ Date: ____/____/_____

14) Have you ever been hospitalized for any reason other than surgery: □ Yes □ No _____

15) <u>Medications:</u> Please list all medications (prescription and non-prescription) you are currently taking or take on a regular basis: _____
_____

16) Your diet is: □ Balanced □ Fair □ Poor □ Excessive □ Restricted

17) <u>Family History:</u> Are there any diseases or condition that are common among your family members (i.e. inherited diseases on conditions): □ Yes □ No _____
_____

Last Name: _____ Date of Birth: _____

18) Please Check the box if you have had or have any of the following:

□ Abdominal pain □ Allergies □ Alcoholism □ Anemia □ Arteriosclerosis

□ Arthritis □ Asthma □ Back pain

□ Breast Lump: Date of Last Mammogram ____/____/_____ □ Broken bones □ Bronchitis

□ Bruise Easily □ Cancer: Type_____□ Chest pain □ Cold Extremities □ Constipation □ Cramps

□ Depression/Anxiety □ Diabetes: Type I Type II □ Difficulty Swallowing □ Digestion Problems

□ Dizziness □ Excessive Menstruation □ Excessive Thirst □ Eye pain or difficulties

□ Fatigue □ Headaches □ Hearing loss □ Heartburn/Indigestion

□ Hemorrhoids □ High Blood Pressure □ Hormone Therapy □ Hot Flashes □ Irregular Heartbeat

□ Irregular Menstrual Cycle □ Jaw/Dental Problems □ Kidney Infection

□ Kidney Stones □ Leg pain □ Loss of Balance □ Loss of Memory □ Loss of Smell

□Loss of Taste □ Nose bleeds □ Pacemaker □ Painful/Frequent Urination

□ Polio □ Poor Posture □ Pregnancy

□ Prostate Troubles: Date of Last Prostate Exam ____/____/_____ □ Seizures/Convulsions

□ Sciatica □ Sinus Infection □ Skin Problems □ Sleep problems/Insomnia

□ Spinal Curvatures □ Stroke □ Swelling of Ankles/Joints

□ Swollen Lymph Nodes □ Thyroid Condition □ Tremor □ Ulcers

□ Varicose Veins □ STD's unspecified □ Other: _____

19) Females ONLY: Ob/Gyn **Mark all that apply below.**

If you have been pregnant in the past, please fill in the appropriate information below.

I… □ am currently pregnant	**□ am NOT currently pregnant**
Please List any Complications:	

20) Social History: **Mark all that apply below.**

Alcohol: □ do not drink alcohol □ social consumption only □ drink the following regularly (mark below)
□ beer □ liquor □ wine; quantity of _____ oz./glasses per □ day □ week □ month

Tobacco: □ Do not use tobacco □ Do not smoke cigars, cigarettes or pipe □ Live with a smoker □ Quit smoking
□ Smoke: # ____ per □ Day □ Week □ Month; □ Chew: #_____cans per □ Day □ Week □ Year

Highest Education Level: _____

Last Name: _____ Date of Birth: _____

I have read and understand the included information and certify it to be true and accurate.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will 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 the Chiropractic Clinic 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 or treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature: _____ Date: _____
Consent to treat a Minor: _____ Date: _____
Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

Witnessed:_____

Date: _____

Last Name: _____ **Date of Birth:** _____

HIPAA Privacy Notice

- Patient Health Information Consent Form
- We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.
- 1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
- 2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
- 3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- 4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
- 5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
- 6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- 7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
- I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature:_____ Date:_____