PATIENT HISTORY: **von Rice Family Chiropractic**

Today's Date: _____ E/M Level IV HRN: _____

PATIENT DEMOGRAPHICS

EMAIL ADDRESS: _____

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____ Home Phone: _____ Fax: _____

Mobile Phone: _____ Work Phone: _____ Fax: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Name of Spouse: _____ Spouse's Employer: _____

Occupation: _____ Ages of your children: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY of COMPLAINT(s)

Please list in order of importance all complaints and the symptoms you are currently experiencing that brought you to this office:

Primary problem _____ 2nd _____ 3rd _____ 4th _____

When did each **problem/symptom begin**: Primary complaint _____ 2nd _____ 3rd _____ 4th _____

Number of times you have experienced: Primary complaint _____ 2nd _____ 3rd _____ 4th _____

When was the last **episode**? Primary complaint _____ 2nd _____ 3rd _____ 4th _____

What relieves your symptom(s)? Primary complaint _____ 2nd _____ 3rd _____ 4th _____

What makes them feel worse? Primary complaint _____ 2nd _____ 3rd _____ 4th _____

On a scale of 1 to 10 with10 being the worst pain and 0 being no pain, rate how you feel today *(Circle the number)*:											**Constant**	**Intermit**
Primary complaint	1	2	3	4	5	6	7	8	9	10		
Second complaint:	1	2	3	4	5	6	7	8	9	10		
Third complaint:	1	2	3	4	5	6	7	8	9	10		
Fourth complaint:	1	2	3	4	5	6	7	8	9	10		
Fifth complaint:	1	2	3	4	5	6	7	8	9	10		

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms: **R** = Radiating **B** = Burning **D** = Dull
A = Aching **N** = Numbness **S** = Sharp/ Stabbing **T**= Tingling

Do your symptoms cause you to feel worse in the ☐ AM ☐ PM ☐ mid-day ☐ late PM

Have these Problems ever been treated by anyone in the past? ☐No ☐Yes **If yes**

Who provided: _____

How long ago? _____What **type** of treatment did you receive? _____

What were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable** please explain:

_____

List any **medications** taken to treat these conditions: _____

Did they help? ☐ No ☐ Yes If you still take them, how often? _____

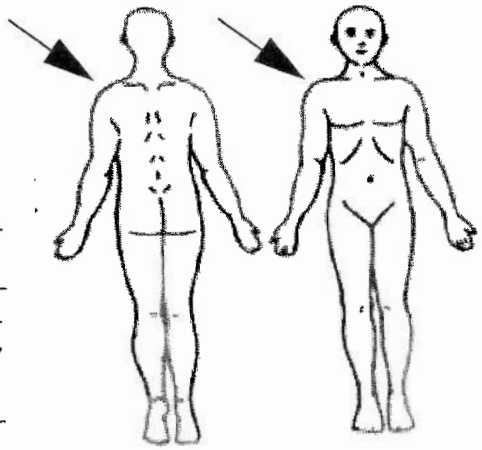
*Have you ever been under chiropractic care? ☐ No ☐ Yes **If yes,** how long ago: _____

Name of Previous Chiropractor: _____

Are any of your problem(s) today the result of ANY **recent accident**? ☐ No ☐ Yes **If yes,**

How long ago? _____ Please explain what type of accident: _____

*Who treated you? _____



PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past, C** for **Currently** have and **N** for **Never** have had:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure

___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis

___ Osteo Arthritis ___ Fracture ___ Diabetes ___ Other serious conditions _____

2. PLEASE, identify **ALL PAST and** or any **unrelated current conditions** you feel may be contributing your present problem:

	HOW LONG-AGO	**TYPE OF CARE RECEIVED**	**BY WHOM**
REVIOUS ACCIDENTS:			
ADULT DISEASES:			
SURGERIES:			
CHILDHOOD DISEASES:			

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes **If yes whom:**
   ❑ Grandmother ❑ Grandfather ❑ Mother ❑ Father ❑ Sister's ❑ Brother's ❑ Son(s) ❑ Daughter(s)
2. Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know
3. **Any** other hereditary conditions the doctor should be aware of ❑ No ❑Yes _____

SOCIAL HISTORY

1. **Smoking**: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. **Alcoholic** Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational **Drug** use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. How many **years** of **school** did you complete? ❑ 1-8 ❑ 8-12 ❑ 12-14 ❑ 14-16 ❑ 16 +

5. ***Please mark with an X under columns 3, 4, 5and 6, the effect your current condition is having on your ability to perform the activity***

COLUMNS→ → →		3	4	5	6
	Related Pain Scale →	1 2 3 4 5	6 7 8	9 10	
ACTIVITY or Movement:	**Measurement**				
Bending neck forward		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Bending neck backward		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Turning neck right to left		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Turning neck left to right		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Twisting from the waste		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Bending side to side		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Bending backward		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Bending forward		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Standing erect		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Going from standing to sitting		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Sitting for periods over		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Going from sitting to standing		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Standing for periods over		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Going form sitting to lying down		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Lying down for more than		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Going from lying to sitting up		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Rolling over when lying down		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Extending arms overhead		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Extending arms forward		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Pushing		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Pulling		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Shoveling		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Lifting more than		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Walking or running		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Climbing uphill (stairs, ladders)		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform
Walking downhill		❑ No Effect	❑ Painful (can do)	❑ Painful (Limits)	❑ Unable to Perform

Signature: Date Completed / / Doctors Sig

Consent to Treatment

von Rice Family Chiropractic

Patients Name: _____ DOB: _____

Medical Record #: _____

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures. One of the rarest complications associated with Chiropractic cares occurring at a rate between one instance per one million to one per two million is a cervical spine (neck) adjustment causing injury to a vertebral artery, which could lead to a stroke.

Risks Associated with Electrical Stimulators include burns, shock, skin irritations & bruising, pain **and interference e with pacemakers.**

Risks associated with Acupuncture include: bleeding, bruising, infection and injury.

I understand the risks associated with chiropractic spinal adjustments, and the above stated modalities and therapeutic procedures used by the practice to treat my current conditions All my questions regarding treatment have been answered to my complete satisfaction, and I have conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature Date

_____ _____ - _____ - _____

Witness Signature Date

_____

Witness Name

von Rice Family Chiropractic
NOTICE OF PRIVACY PRACTICE

This office is required to notify you writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation and how you may obtain access to that information. In addition we are providing you with a list of potential circumstances under which by law, or in accordance with our office policy, we **may** disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this 'Notice' please sign the last page and return only the signature page (page 3) to our front desk receptionist.

PERMITTED DISCLOSURES

1. For treatment purposes- discussion with other health care providers involved in your care
2. *Inadvertent disclosures- services may be rendered in an open treating area, which means open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.*
3. For payment purposes - to obtain payment from any insurance company or other available collateral source, OR
4. To obtain a recent address on you in the event you move and do not leave a forwarding address, we may use your 'emergency contact information' in whatever way necessary to locate you and collect any outstanding sums you may owe the practice/doctor.
5. For workers compensation purposes- to process a claim or aid in investigation
6. Emergency- in the event of a medical emergency we may notify a family member
7. For Public health and safety - in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
8. To Government agencies or Law enforcement, to identify or locate a suspect, fugitive, material witness or missing person.
9. For military, national security, prisoner and government benefits purposes.
10. Deceased persons –discussion with coroners, medical examiners and family members or others who were involved in the care or payment for care of the decedent prior to death,
11. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or up coming events.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI
13. To send communications while you are being treated and we are receiving financial remuneration
14. Speaking with the patient's guardian or representative regarding bill payment
15. Providing therapy to patients in group settings
16. We may discuss your PHI using personal mobile phones when necessary to facilitate discussion about your care and or record keeping of your care.

Any other uses of disclosures not described in the Notice of Privacy Practices will be made only after obtaining your prior written authorization.

Note: ***At any time, this office may update the list of ways your PHI may be used and all updates are deemed retroactive.***

von Rice Family Chiropractic

YOUR RIGHTS

1. To receive an accounting of disclosures
2. To receive a paper copy of a more detailed /comprehensive Privacy Notice
3. To request mailings to an address different than your residence
4. You have the right to request and receive electronic copies of your records
5. To request amendments to information, however like restrictions we are not required to agree to them
6. You have the right to receive notification in the event of a breach of unsecured PHI
7. To request restrictions on certain uses and disclosures and, however we are not required to comply with your request.
8. With advance notice of at least five business days to the practice you may inspect your records and receive one copy of your records at no charge.
9. You have the right to request and we as a covered entity will restrict disclosure of your personal health information to a health plan if disclosure pertains to a healthcare item or service which you have personally paid out of pocket for in full.
10. You have the right to NOT receive communications regarding fund raising and none will be sent to you unless you give us written authorization

ADDITIONAL RESPONSIBILITIES OF THIS PRACTICE

1. We are required to obtain a separate signed authorization from you before your personal health information can be used in marketing and for any disclosures that constitute a sale of personal health information.
2. We are required to notify you and HHS in the event of a breach caused by any of our business associates.
3. We are responsible to look over our business associate contracts to ensure they comply with the Omnibus Rules and requirements.
4. With prior authorization from you, we may contact you to send you information concerning products or services and information related or unrelated to your health.

COMPLAINTS:

If you wish to make a formal complaints about how we handle your health information please call Angela Powell at 480-570-4204 If she is unavailable, you may make an appointment with our receptionist to see the Doctor within 2 working days. If you are still not satisfied wit the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

***Continued* from page 2 of 3 →** *Patient initials* _____.

REGARDING NOTICE OF YOUR RIGHT TO PRIVACY

Patient:_____ DOB: _____HR#:_____

My signature below is an acknowledgement that I have received a copy of _____ ***Chiropractic Patient Privacy Notice.*** I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of this information to the doctor and do not have any question regarding my rights or any of the information I have received at this time.

I have been made aware that additional information regarding HIPAA and my rights is published in government newsletters, which are available to me online.

The first two original pages of this 'Notice' have been given to me to keep.

_____ _____
Patient signature Date

_____ _____
Witness Date

_____ _____
Print Witness Name Date

von Rice Family Chiropractic

AUTHORIZATION TO OBTAIN PATIENT INFORMATION

Today's Date: _____/_____/_____ HR#:_____

Patients Name: _____ DOB: _____/_____/_____

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In accordance with the laws governing the state of Arizona or the laws governing the state in which my injury(s) occurred,

I hereby authorize and direct _____ to release to von Rice Family Chiropractic, all information maintained in my Personal Health Record, so that an appropriate decision can be made as to the clinical course of care I will need to treat my presently problems

I also understand that I have the right to revoke this Authorization at any time although such revocation would not include any previously authorized disclosures.

My signature below is conveyance that I am not limiting this authorization and that all information maintained by (Facility or Provider) as part of my health care record should be forwarded without restriction.

This Authorization expires,

1. one year from today
2. on ____/____/____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____