Confidential Patient Information
Case History

Name _____ Date _____
E-mail Address_____
Phone #_____ Would you like appt reminders? __ Cell provider_____
Address_____
City _____ State_____ Zip _____
Age_____ Birth Date_____ Marital Status: M S W D
Occupation _____Employer _____
Address_____ Office Phone _____
Student at _____Full Time ___Part Time ___
Name of Spouse _____ Occupation _____
Employer _____ Address _____
Name of Nearest Relative _____
Address_____ Phone _____
How did you hear about our office? _____
Purpose of this appointment _____
Other doctor seen for this condition _____ Ph. # _____
Have you been treated for any health condition by a physician in the last year? YES NO
Describe_____
Do you currently or have you had any major illnesses or conditions? _____
_____
What medications or supplements are you taking? _____
_____
_____
Primary Care Physician _____ Ph. # _____

Personal History:

- Arthritis
- High/ low blood pressure
- Cancer
- Ulcers
- Chronic fatigue
- Fibromyalgia
- Gastritis
- Liver/ gallbladder disease
- Hypo /hyperglycemia
- Diabetes
- Seizures
- Anemia
- Stroke
- Allergies
- Hepatitis
- Thyroid issues
- Chronic pain condition
- Infertility
- Heart disease
- High blood cholesterol
- Diverticulitis
- IBS
- Raynaud's disease
- Emphysema
- Lymes disease
- Kidney disease

Family History:

- Diabetes
- High blood pressure
- Seizures
- Allergies
- Heart disease
- Cancer
- Stroke
- Asthma
- Other (please list):
- Poor sleep

PLEASE CHECK IF YOU HAVE HAD ANY OF THESE SYMPTOMS LISTED IN THE LAST THREE MONTHS:

General:
- o Poor appetite
- o Fever/ chills
- o Changes in appetite
- o Bleed/ bruise easily
- o Muscle weakness /fatigue
- o Night sweats
- o Significant weight gain/ loss
- o Poor balance
- o Tremors
- o Dental/ gum problems

Skin and Hair:
- o Rashes
- o Eczema
- o Psoriasis
- o Skin discoloration
- o Ulcerations
- o Dandruff
- o Acne
- o Hives
- o Loss of hair
- o Change in skin/ hair texture
- o Itching
- o Moles
- o Lacerations and scarring

Head, ears, nose, and throat:
- o Dizziness
- o Eye strain
- o Color blindness
- o Ringing in ears
- o Nosebleeds
- o Headaches/ migraines
- o Difficulty swallowing
- o Eye pain
- o Cataracts
- o Poor hearing
- o Teeth grinding
- o Jaw locks/ clicks
- o Night blindness
- o Earaches
- o Sinus problems
- o Facial pain
- o Soreness or lips/ tongue
- o Facial paralysis
- o Recurring cold/ flu like symptoms
- o Eye glasses/ contacts
- o Blurred/ poor vision

Cardiovascular:
- o Chest pain
- o Cold hands/ feet
- o Shortness of breath
- o Irregular heartbeat
- o Swelling of hands/ feet
- o Heart palpitations at rest
- o Blood clots
- o Pressure in chest
- o Fainting spells
- o Varicose/ spider veins

Respiratory:
- o Cough
- o Difficulty breathing
- o Pneumonia
- o Coughing up blood
- o Pain with inhalation
- o Asthma
- o Tightness in chest
- o Bronchitis
- o Wheezing
- o Production of phlegm
- o Other (please list):

Gastrointestinal:
- o Nausea
- o Gas
- o Belching
- o Indigestion
- o Bloating/ edema
- o Changes in appetite
- o Vomiting
- o Acid reflux
- o Other (please list):
- o Diarrhea
- o Black stools
- o Rectal pain
- o Loose stools (> 2x per day)
- o Hernia
- o Constipation
- o Bloody stools
- o Hemorrhoids
- o Abdominal pain/ cramps

Neuropsychological:
- o Seizures
- o Lack of coordination
- o Anxiety/ depression
- o Loss of balance
- o Poor memory
- o Bad temper/ irritable
- o Sudden mood changes
- o Vertigo/ dizziness
- o Concussion
- o Susceptible to stress
- o Areas of numbness

PIEDMONT CHIROPRACTIC CENTER, P.A.
because spinal alignment matters

Health Questionnaire

Patient Name_____ Date_____

1. Describe your condition. _____
_____

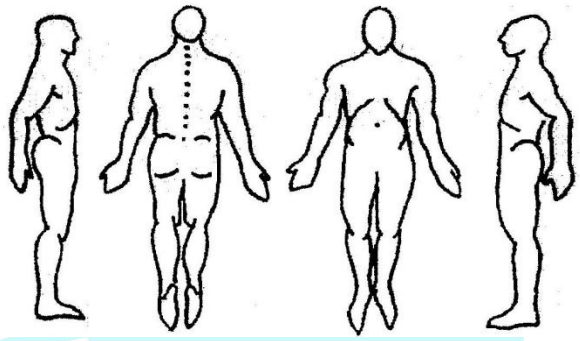
a. When did your dysfunction begin? Most recent flare up? _____
b. How did your dysfunction begin? **Any recent falls or traumas**? _____

2. How often do you experience your dysfunction?

(Circle)

1. Constantly (76-100% of the day)
2. Frequently (51-75% of the day)
3. Occasionally (26-50% of the day)
4. Intermittently (0-25% of the day)

Mark where you experience pain below



3. What describes the nature of your dysfunction?

1. Sharp	4. Shooting	7. Stiffness
2. Dull ache	5. Burning	8. Loss of motion
3. Numb	6. Tingling	9. Weakness

4. Indicate the average intensity of your dysfunction- None Unbearable

During the last 24 hours	0	1	2	3	4	5	6	7	8	9	10
During the last week/s	0	1	2	3	4	5	6	7	8	9	10

5. How much has your dysfunction interfered with your normal work (includes work outside the home and housework) or social activities?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

6. Health -**Are you pregnant or trying to become pregnant**? _____ # of weeks_____no possibility____

7. In general how is your overall health?

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor

8. **Have you been diagnosed with disc or joint disease**, who have you seen? _____

1. No one 2. Medical Doctor 3. Chiropractor (other or this office) 4. Physical Therapist

a. What treatment did you receive and when?

_____

b. What tests have you had for your symptoms? When and where were they performed?

X-rays-date____CT scan-date____MRI-date_____ Bone Density _____Nerve Testing or other-date____

_____

9. Do you have bone or joint weakness or wasting disease? If so, describe _____
Including but not limited to osteopenia, osteoporosis, tendon, or muscle conditions.

10. **Have you had any broken bones, surgeries** (recent & unhealed, spinal, or joint related, gallbladder, kidney stones, female, prostate or fusions of the spine or **any implants mechanical /electrical i.e., pacemakers, shunts, etc. affected by electrical current, magnets /batteries, MRI?** _____

_____

11. What is your occupation? Professional /Student / Retired (sedentary) or Tradesperson (physical)

12. What kind of occupational, social, or recreational activities do you practice that may affect your condition? _____

Patient Signature_____Date_____

PIEDMONT CHIROPRACTIC CENTER, P.A.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you**
  We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**
- We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: The patient allows the office to send courtesy information e-mails regarding rehabilitative stretching and strengthening exercises, nutrition, office promotions, and birthday cards, and the right to post their name on the bulletin board for referring other patients.*
- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

I understand and agree that health insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company. If mine is a regular health insurance case, I agree to pay a copay or percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. If payment is not received after 30 days of receiving bill interest will accrue at 18 percent per annum. I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective September 23, 2013

Before we 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.

1. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
2. The patient may provide a written request to revoke consent at any time during care. This would not affect 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.
3. 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.
4. 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.
5. This release gives our office permission to view your EMR via electronic portals with other facilities.

I give permission to Piedmont Chiropractic Center and its representatives to share my health or billing information with the following people who are involved in my care:

Name	***Relationship***	***Contact Number***
_____	_____	_____

☐ If you would like to have the report from your initial visit emailed to you please check here. We have the ability to send additional visit records via email, upon request.

I have read and understand how my **Patient Health Information** will be used, and I agree to these policies and procedures.

_____

Signature of Patient Date

INFORMED CONSENT FORM

PIEDMONT CHIROPRACTIC CENTER, P.A.
because spinal alignment matters

PATIENT NAME: _____ DATE:_____

To the patient: Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Chiropractic physician is spinal manipulative therapy in most cases. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- range of motion testing
- muscle strength testing
- palpation (motion & static)
- vital signs
- orthopedic testing
- postural analysis
- radiographic studies (to be done off- site)
- acupuncture
- cold laser treatment
- leVel drop board
- hot/cold therapy
- manual therapy
- rehabilitative stretches
- electric stim/ interferential
- mechanical traction (flexion/extension)

Dr. Parks developed a drop board that is believed to be safer and more effective than the traditional drop technique. If you would prefer not to use this experimental equipment, please exclude the leVel drop board from the treatment option above. ***This is not a conventional medical treatment and if you are not interested in this please inform Dr. Parks.***

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and other therapies used in offices like ours. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. We are proud to be a leader in the manual therapy field that strives to improve patient outcomes with improved equipment.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options, and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed any questions with *Dr. David Parks* and have had them answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

_____ **Dr. David Parks**

Patient's Name **Doctor's Name**

_____ _____

Signature **Signature**

_____

Signature of Parent or Guardian

(If a minor)