Patient Information Form

Case #

Doctor/Staff Use Only

Dr. _____

Dx. 1 _____, 2 _____

3 _____, 4 _____

5 _____, 6 _____

7 _____, 8 _____

Do. _____

Legal Name: _____ Gender: ☐ M ☐ F

Home Phone: _____ Cell Phone: _____

Name you prefer to be called by: _____

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ DOB: ____/____/____

Are you employed? ☐ yes ☐ no Employer: _____

Wk Phone: _____

Language: ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Race: ☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black/African American ☐ Hispanic/Latino ☐ Decline to answer ☐ Other _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to answer

How did you hear about us? _____ Marital Status: ☐S ☐M ☐D ☐W

Name of Ins. Policy Holder: _____ Date of Birth: _____

Spouse's Name (if applicable): _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

Has anyone in your household been a patient here before? ☐ yes _____, _____ ☐ no

Who is responsible for this bill? _____

How would you prefer to be contacted? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail ☐ Text Message

Cell. Carrier: _____

- *I hereby instruct and direct my insurance company to pay by check made out and mailed to Tuck Chiropractic Clinic.*
- *I authorize the release of information by any media pertinent to my case to any insurance company, adjuster, or attorney involved in this case, and verification of employment.*
- *I also authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.*
- *I understand that I am financially responsible to Tuck Chiropractic Clinic for all charges incurred and not covered by the insurance, workers compensation and any collection, thirty-three and one third per cent (33 1/3%) attorney fees, interest and/or cost accrued in trying to collect this account.*
- *I understand any balances over 90 days are subject to accrued interest of 1.5 percent per month.*
- *I have read all information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.*

Signature: _____ Date: _____

Parent (if minor): _____ Date: _____

HIPAA Compliance Acknowledgement of Receipt

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notices of our privacy practice. We protect your health information and what rights you have regarding it, if we need to disclose your health information outside of our office for these reasons we will ask for your written permission. If you would like a copy of this policy please feel free to ask for one.

I acknowledge that I have reviewed this policy and that I was offered a copy of the "Notice of Privacy Practices".

Signature: _____ Date: _____

Past / Family / Social / Occupational History

Case #

Legal Name: _____ **Date:** _____/_____/_____

Illness(es)

☐ *This section N/A*

Past/Current Condition(s)	Approximate Date Age of Diagnosis	Past/Current Condition(s)	Approximate Date Age of Diagnosis
☐ **Allergies/Sinus**	_____	☐ Heart Disease	_____
☐ None ☐ Food ☐ Environmental ☐ Medication		☐ **High Blood Pressure**	_____
☐ Cancer	_____	☐ HIV	_____
☐ Depression	_____	☐ Kidney Stones	_____
☐ **Diabetes**	_____	☐ Respiratory/Lung	_____
☐ Type I ☐ Type II		☐ Stroke	_____
☐ Fibromyalgia	_____	☐ Thyroid - Condition	_____
☐ Headaches	_____	☐ Ulcers/Stomach	_____
		☐ Other	_____

Surgery(s)

☐ *This section N/A*

Body Region	Approximate Date/Age	Body Region	Approximate Date/Age
☐ Abdominal	_____	☐ Foot/Ankle	_____
☐ Back	_____	☐ Hip	_____
☐ Dental	_____	☐ Knee	_____
☐ Fertility/Birth Control	_____	☐ Lung	_____
☐ Gallbladder	_____	☐ Neck	_____
☐ Heart	_____	☐ OB/GYN	_____
☐ Hernia	_____	☐ Shoulder	_____
		☐ Other	_____

Medication(s)

☐ *This section N/A*

☐ None

Start Date	Brand Name	Dosage	Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Mother	Father
☐ Back Pain	☐ Back Pain
☐ Cancer	☐ Cancer
☐ Depression	☐ Depression
☐ Diabetes	☐ Diabetes
☐ Type I ☐ Type II	☐ Type I ☐ Type II
☐ Headaches	☐ Headaches
☐ Heart Disease	☐ Heart Disease
☐ High Blood Pressure	☐ High Blood Pressure
☐ HIV	☐ HIV
☐ Respiratory/Lung	☐ Respiratory/Lung
☐ Stroke	☐ Stroke
☐ Thyroid - Condition	☐ Thyroid - Condition
☐ Ulcers/Stomach	☐ Ulcers/Stomach
☐ Deceased	☐ Deceased

☐ ***This section N/A***

Social History

	Yes	No
• Do you have a balanced diet?	☐	☐
• Do you eat fast food frequently?	☐	☐
• Do you take vitamins?	☐	☐
• Do you exercise routinely?	☐	☐
• Do you sleep well?	☐	☐
• **Do you smoke/use tobacco?**	☐	☐
• Do you drink alcohol?	☐	☐

Occupational History

- What is your current occupation?

  _____
- Describe your work:
  - ☐ Office/Computer
  - ☐ Light Labor
  - ☐ Moderate Labor
  - ☐ Heavy Labor
  - ☐ Repetitive
  - ☐ Stressful
- What was your occupation prior to your current position? _____

History of the Present Illness - Primary

Case #

Legal Name: _____ Date: _____/_____/_____

#1 History of the Present Illness - <u>What hurts the most; why are you here?</u>

L Location of present Complaint: _____

M Was there a particular event that caused the pain or problem? ☐ Y ☐ N

- If yes, describe: _____

N Are you a new or returning patient? ☐ New ☐ Returning

O When did your present complaint begin? Date: _____/_____/_____

P What aggravates your condition/pain? _____

P What lessens your condition/pain? _____

Q Which of these are you feeling:

☐ Numbness ☐ Pins and Needles ☐ Burning ☐ Aching ☐ Stabbing ☐ Dull Ache

R Does the pain/sensation spread or radiate to other areas? ☐ Y ☐ N

- If yes, please describe: _____

S Please rate your condition/pain on a scale of 0 to 10. **0= no pain 10=most severe pain**

- What is the severity of your pain RIGHT NOW? 0 1 2 3 4 5 6 7 8 9 10
- What is the severity of your pain AT ITS BEST? 0 1 2 3 4 5 6 7 8 9 10
- What is the severity of your pain AT ITS WORST? 0 1 2 3 4 5 6 7 8 9 10

T Is the condition/pain worst during certain times of day? ☐ Y ☐ N Time: _____

Since the condition/pain began, has it gotten: ☐ Better ☐ Worse ☐ Stayed about the same

Review of Systems: Musculoskeletal and Nervous

In addition to the above condition/pain do you have any of the following symptoms?

☐ None ☐ Limited movement ☐ Difficulty walking ☐ Dizziness ☐ Headache

☐ Lack of coordination ☐ Popping noises ☐ Stiffness ☐ Visual disturbances ☐ Weakness

Name of Primary Care Physician: _____

Have you been treated for any healthcare condition by a physician in the last year? ☐ Y ☐ N

- If yes, describe: _____

For Female Patients: X-ray Information and Consent

This is to certify to the best of my knowledge I AM NOT PREGNANT and that Tuck Chiropractic Clinic has my consent to take x-rays.

_____/_____/_____
Date of last menstrual cycle

_____
Signature

_____/_____/_____
Today's Date

Tuck CHIROPRACTIC

History of the Present Illness - Secondary

Case #

Complete this form only if you have more than one complaint.

Legal Name: _____ Date: _____/_____/_____

#2 History of the Present Illness - What else hurts; what is the next worst thing?

L Location of present Complaint: _____

M Was there a particular event that caused the pain or problem? ☐ Y ☐ N
- If yes, describe: _____

N Are you a new or returning patient? ☐ New ☐ Returning

O When did your present complaint begin? Date: _____/_____/_____

P What aggravates your condition/pain? _____

P What lessens your condition/pain? _____

Q Which of these are you feeling:
☐ Numbness ☐ Pins and Needles ☐ Burning ☐ Aching ☐ Stabbing ☐ Dull Ache

R Does the pain/sensation spread or radiate to other areas? ☐ Y ☐ N
- If yes, please describe: _____

S Please rate your condition/pain on a scale of 0 to 10. **0= no pain 10=most severe pain**
- What is the severity of your pain RIGHT NOW? 0 1 2 3 4 5 6 7 8 9 10
- What is the severity of your pain AT ITS BEST? 0 1 2 3 4 5 6 7 8 9 10
- What is the severity of your pain AT ITS WORST? 0 1 2 3 4 5 6 7 8 9 10

T Is the condition/pain worst during certain times of day? ☐ Y ☐ N Time: _____
Since the condition/pain began, has it gotten: ☐ Better ☐ Worse ☐ Stayed about the same

#3 History of the Present Illness - Is there anything else that hurts?

L Location of present Complaint: _____

M Was there a particular event that caused the pain or problem? ☐ Y ☐ N
- If yes, describe: _____

N Are you a new or returning patient? ☐ New ☐ Returning

O When did your present complaint begin? Date: _____/_____/_____

P What aggravates your condition/pain? _____

P What lessens your condition/pain? _____

Q Which of these are you feeling:
☐ Numbness ☐ Pins and Needles ☐ Burning ☐ Aching ☐ Stabbing ☐ Dull Ache

R Does the pain/sensation spread or radiate to other areas? ☐ Y ☐ N
- If yes, please describe: _____

S Please rate your condition/pain on a scale of 0 to 10. **0= no pain 10=most severe pain**
- What is the severity of your pain RIGHT NOW? 0 1 2 3 4 5 6 7 8 9 10
- What is the severity of your pain AT ITS BEST? 0 1 2 3 4 5 6 7 8 9 10
- What is the severity of your pain AT ITS WORST? 0 1 2 3 4 5 6 7 8 9 10

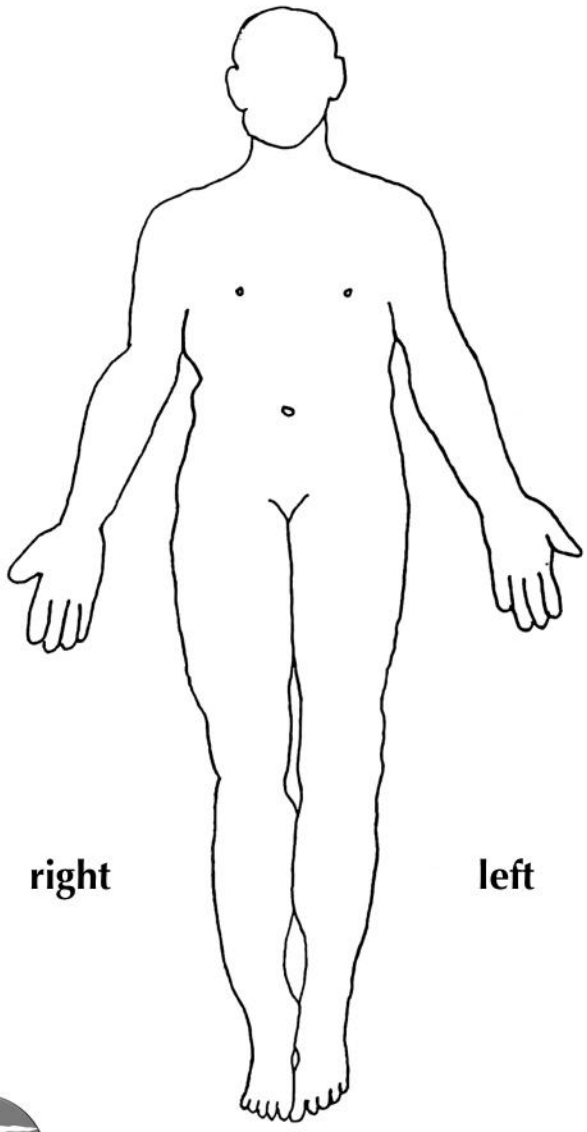
T Is the condition/pain worst during certain times of day? ☐ Y ☐ N Time: _____

Pain Drawing

Name: _____ Date: ____/____/____ File: _____

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark the areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing/Sharp
- - - - -	00000	XXXXX	******	/ / / / /
- - - - -	00000	XXXXX	******	/ / / / /
- - - - -	00000	XXXXX	******	/ / / / /



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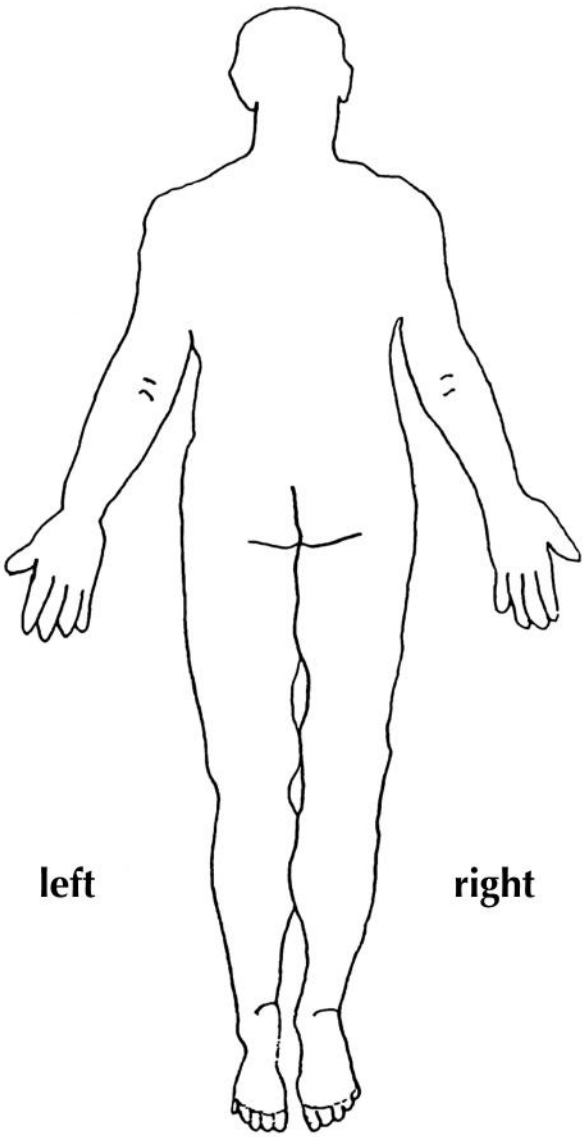

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Release of Information Authorization Form

Case No: _____

I hereby authorize Tuck Chiropractic Clinics and its affiliates, employees and agents collectively to release information.

Information to Be Used or Disclosed • The information covered by this authorization includes:

- ■ Healthcare and Financial records
  - Healthcare records include examination findings, diagnoses, treatments, lab/imaging results and health information gathered from other sources on my behalf.
- ☐ Healthcare records
- ☐ Financial records

Purposes of Disclosure • Information listed above will be disclosed for the following purposes:

- ■ All of the following
- ☐ To assist in coordination of healthcare (ordering of lab/imaging studies, obtaining second opinions, transferring care, honor records requests from other healthcare providers per the patient's request)
- ☐ To assist in obtaining payment for healthcare provided by Tuck Chiropractic Clinics

Persons to Whom Information May Be Disclosed • Information described above may be disclosed to:

- ■ All of the following
- ☐ Personal Attorney
- ☐ Primary Insurance Carrier
- ☐ Guardian/Parent
- ☐ Secondary/Insurance Carrier
- ☐ Spouse
- ☐ Other Healthcare Providers as described above
- ☐ Release to: _____

Right to Terminate or Revoke Authorization

I understand that I have a right to revoke this authorization by providing written notice to Tuck Chiropractic Clinics. However, this authorization may not be revoked if Tuck Chiropractic Clinics, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

Potential for Redisclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Tuck Chiropractic Clinics discloses it to another party.

Rights of the Individual

You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditional on whether I sign the authorization.

I prefer these records be released:

- ■ Any of the following
- ☐ Sent by fax
- ☐ Directly to me
- ☐ Sent by e-mail
- ☐ Sent by mail
- ☐ By phone

Note: _____

_____	_____	____/____/____
Name of Patient	Signature of Patient	Date
_____	_____	____/____/____
Name of Witness	Signature of Witness	Date

If applicable, Legal Representatives sign below • By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____	_____	____/____/____
Name of Legal Representative	Signature of Legal Representative	Date
_____	_____	____/____/____
Name of Witness	Signature of Witness	Date

Expiration Date of Authorization

This authorization is effective one year from the date signed unless revoked or terminated earlier by the patient or the patient's personal representative.