APPLICATION FOR CARE AT Hill Family Chiropractic, P.A.

Whom may we thank for referring you to this office? _____

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ **Birth Date:** _____-_____-_____ **Age:** _____ □ **Male** □ **Female**

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

E-mail Address: _____ **Home Phone:** _____ **Mobile Phone:**_____

Marital Status: □ **Single** □ **Married** **Do you have Insurance:** □ **Yes** □ **No** **Work Phone:** _____

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

Employer: _____ **Occupation:** _____

Spouse's Name _____ **Spouse's Employer** _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ _____ **Relationship:** _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office:

Primary: _____ **Secondary:** _____

Third: _____ **Fourth:** _____

On a scale of **1** to **10.** With **10** being the **worst** pain and **zero** being **no** pain: Rate your above complaints by ***CIRCLING THE NUMBER:***

Primary: complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second: complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third: complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth: complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? □ **AM** □ **PM** □ **Mid-Day** □ **late PM**
How long does it last? □ **It is constant OR** □ **I experience it on and off during the day OR** □ **It comes and goes throughout the week**

How did the injury happen?_____

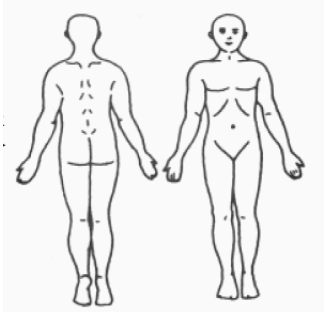
Condition(s) ever been treated by anyone in the past? □**No** □ **Yes (If yes):**

When & By whom? _____ How long were you under care: _____

What were the results? _____ Name of Previous Chiropractor: _____ □ **N/A**

What **relieves** your symptoms? _____

What makes your symptoms **feel worse**? _____



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

LIST RESTRICTED ACTIVITY:	**CURRENT ACTIVITY LEVEL:**	**USUAL ACTIVITY LEVEL:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? □ No □ Yes **If yes,** how many times? _____
When was the last episode? _____ How did the injury happen?_____
Other forms of treatment tried: □ **No** □ **Yes** **(If yes)** please state **what type of treatment**: _____,
who provided it: _____, **How long ago: _____, What were the results:_____**
□ **Favorable**
□ **Unfavorable**□ please explain. _____
Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

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 or **N** for **Never** have had**:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer

___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular __ Other serious conditions: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES □			
SURGERIES □			
CHILDHOOD DISEASES □			
ADULT DISEASES □			

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. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect? (See **ADL** form)

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)**
Have they ever been treated for their condition? □ **No** □ **Yes** □ **I don't know**
2. Any other **hereditary** conditions the doctor should be aware of? □ **No** □ **Yes**: _____

Is your problem the result of ANY type of accident? □ Yes, □ No

Patient signature: _____ Today's Date: __/__/__

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sit to Stand	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climb Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pet Care	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Extended Computer Use	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lift Children/Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Read/Concentrate	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Getting Dressed	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Shaving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sexual Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleep	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Sitting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Washing/Bathing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sweeping/Vacuuming	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dishes	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Laundry	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Garbage	□ No Effect	□ Painful (can do)	□ Painful (limits	□ Unable to Perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other: _____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

List Prescription & Nonprescription drugs you take: _____

_____

_____

WHO IS YOUR M.D: _____

***We offer massages by a licensed massage therapist. Will you be implementing the benefits of massage therapy in your care? _____**

Patient signature: _____ Today's Date: __/__/__

Continued on next page

Hill Family Chiropractic, P.A.

Please Mark **using the letters: P for in the** Past**, C for** Currently **have, or N for** Never**:**

- ☐ **HEADACHE**
- ☐ **NECK PAIN**
- ☐ **JAW PAIN/ TMJ**
- ☐ **SHOULDER PAIN**
- ☐ **UPPER BACK PAIN**
- ☐ **MID BACK PAIN**
- ☐ **LOW BACK PAIN**
- ☐ **HIP PAIN**
- ☐ **BACK CURVATURE**
- ☐ **SCOLIOSIS**
- ☐ **NUMBNESS/TINGLING (ARMS HAND,FINGERS)**
- ☐ **NUMBNESS/TINGLING (LEG,FEET,TOES)**
- ☐ **HIV/AIDS**
- ☐ **CURRENTLY PREGNANT**
- ☐ **FREQUENT COLDS/FLU**
- ☐ **CONVULSIONS/EPILEPSY**
- ☐ **TREMORS**
- ☐ **CHEST PAIN**
- ☐ **PAIN WHEN COUGHING/SNEEZING**
- ☐ **FOOT OR KNEE PAIN/PROBLEMS**
- ☐ **SINUS/DRAINAGE ISSUES**
- ☐ **SWOLLEN/PAINFUL JOINTS**
- ☐ **SKIN PROBLEMS/ISSUES**
- ☐ **TROUBLE SLEEPING**
- ☐ **ULCERS**
- ☐ **DIZZINESS**
- ☐ **LOSS OF BALANCE**
- ☐ **SYNCOPE (FAINTING)**
- ☐ **BLURRED VISION**
- ☐ **DOUBLE VISION**
- ☐ **RINGING IN EARS**
- ☐ **LOSS OF HEARING**
- ☐ **DEPRESSION**
- ☐ **IRRITABILITY**
- ☐ **CHANGES IN MOOD**
- ☐ **ADD/ADHD**
- ☐ **ALLERGIES**
- ☐ **PROSTATE PROBLEMS**
- ☐ **IMPOTENCE/SEXUAL DYSFUNCTION**
- ☐ **DIGESTIVE PROBLEMS**
- ☐ **COLON TROUBLE**
- ☐ **DIARRHEA/CONSTIPATION**
- ☐ **MENOPAUSAL PROBLEMS**
- ☐ **MENSTRUAL PROBLEMS**
- ☐ **PMS**
- ☐ **BED WETTING**
- ☐ **LEARNING DISABILITIES**
- ☐ **EATING DISORDER**
- ☐ **HEARTBURN**
- ☐ **HEART CONDITION**
- ☐ **HIGH BLOOD PRESSURE**
- ☐ **LOW BLOOD PRESSURE**
- ☐ **ASTHMA**
- ☐ **DIFFICULTY BREATHING**
- ☐ **LUNG CONDITION**
- ☐ **KIDNEY CONDITION**
- ☐ **GALL BLADDER CONDITION**
- ☐ **LIVER CONDITION**
- ☐ **HEPATITIS (A/B/C)**

Patient signature: _____ **Today's Date:** __/__/__

Hill Family Chiropractic, P.A.

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Hill Family Chiropractic, P.A. have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature ***Date***

REGARDING: X-rays/Imaging Studies

FEMALES ONLY ☐ *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ **The first day of my last menstrual cycle was on** ____-____-____ **(Date)**

☐ I have **been provided** a full explanation of when I am most likely to **become pregnant**, and to the **best of my knowledge**, I am **not** pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature **Date**

I hereby authorize payment to be made directly to Hill Family Chiropractic, P.A. for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Hill Family Chiropractic, P.A. for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

HILL FAMILY CHIROPRACTIC, P.A. NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to 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. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating areas mean 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 your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. 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 upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different from residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call our office at (386) 226-0081. You may make an appointment with our receptionist within 72 hours or 3 working days. If you are still not satisfied with 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

Hill Family Chiropractic, P.A.

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Hill Family Chiropractic, P.A. Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____ _____
Patient's Name **DOB** HR#

_____ _____
Patient's Signature **Date**

_____ _____
Witness **Date**

Medical Information Release Form: **(HIPAA RELEASE FORM)**

Name: _____ Date of Birth: _____

➔ **Release of Information:**

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] Information is not to be released to anyone.

*This **Release of Information** will remain in effect until terminated by me in writing.

***Messages*: (PLEASE CALL MY)**

( ) HOME ( ) WORK ( ) MOBILE

If unable to reach me: ( ) you may leave a detailed message ( ) leave a message asking me to return your call

The best time to reach me is **(*day*)** _____ between **(*time*)** _____

Signed: _____ Date: _____

Witness: _____ Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

---

1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.