Adult Member Health Record

Patient Information

First Name: Last Name: Date:

Date of Birth: Age: Sex: ◯ Male ◯ Female Phone: - - cell/home

◯ Check if you want text reminders for apts.

Marital Status: # of children: Occupation:

Street Address: Height: ft in

City: State: Zip: Weight:

Email: Insurance Company:

Employers Name: Address: Phone: - -

Emergency Contact: Relation: Phone: - -

How did you hear about our office? If you were referred in, who referred you to our office?

Who is your primary care physician? Date and reason for last visit:

Are you receiving care from any other health care provider? ◯ Yes ◯ No What is their specialty?

Please note any significant medical history:

Current Health Conditions

What health condition(s) bring you to our office?

Have you ever received care for the condition before? ◯ Yes ◯ No If yes, please explain:

When did the condition(s) begin?

Is the purpose of this appointment related to: ◯ Chronic Discomfort ◯ Home Injury ◯ Sports ◯ Auto Injury ◯ Fall ◯ Work Injury ◯ Other:_____

If job related have you made a report of the accident to your employer? ◯ Yes ◯ No

How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Is the condition? ◯ Getting Worse ◯ Staying the same ◯ Improving ◯ Come and Gone ◯ Unsure

What makes the condition better? What makes the condition worse?

The condition(s) interferes with: ◯ Sleep ◯ Daily Routine ◯ Other Activities

Please Explain:

Last Name, First Name:

Chiropractic Experience

Have you ever been adjusted by a chiropractor? ○ Yes ○ No

If so, what was the reason for those visits?

Doctor of Chiropractics Name? Approximate Date of Last Visit:

What would you like to gain from chiropractic care? ○ Resolve Existing Condition(s) ○ Overall Wellness ○ Both

Do you have any health concerns for any other family members today?

Health Habits

Do you smoke? ○ Yes ○ No How often?

Do you drink alcohol? ○ Yes ○ No How many drinks per week?

Do you drink coffee, tea, or soda? ○ Yes ○ No

Do you exercise regularly? ○ Yes ○ No

If so how many times per week? _____

If no, is that something you would like to improve? ○ Yes No○

Trauma/Physical Injury History

Have you had any significant falls, injuries, or surgeries as an adult? ○ Yes ○ No If yes, explain:

Have you had any significant falls, injuries, or surgeries as a child? ○ Yes ○ No If yes, explain:

Youth or College Sports Injury? ○ Yes ○ No If yes, explain:

Any Auto Accidents? ○ Yes ○ No If yes, explain:

Any problems with flexibility? (exp. putting on socks/shoes/etc.)

How many hours a day do you typically spend sitting at a desk, computer, tablet, phone, etc?

Health Conditions

Please **CIRCLE** each of the conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and possibility of being accepted for care.

Severe or frequent headaches	Thyroid Problems	Pain in arms/legs/hands	Numbness
Heart Surgery/Pace Maker	Sinus Problems	Low Blood Pressure	Allergies
Lower Back Problems	Hepatitis	Rheumatic fever	Diabetes
Digestive Problems	Difficulty breathing	Ulcers/colitis	Asthma
Pain Between Shoulders	Kidney problems	Tuberculosis	Loss of Sleep
Congenital Heart Defect	High blood pressue	Arthritis	Dizziness
Frequent Neck Pain	Chemotherapy	Shingles	Other_____

Last Name, First Name:

Medications

○ Cholesterol ○ Blood Pressure ○ Stimulants ○ Blood Thinners ○ Glucose ○ Pain Killers

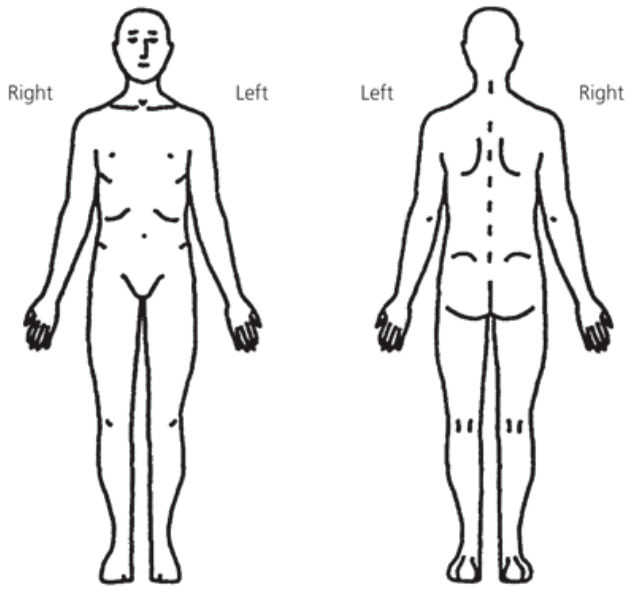
○ Aspirin/etc. ○ Muscle Relaxers ○ Insulin ○ Others:_____

Please list any vitamins or supplements that you take on a regular basis: _____

_____

Your Conditions

1) Please indicate where you are experience pain/discomfort:
X= Current. O= Past Conditions



2) Using the pain scale below, circle the level you experience when the problem/s is at its worst:

0=**No Pain**. No Discomfort
1=**Minimal Discomfort**. Minor stiffness or tightness.
2=**Mild Pain**. Noticeable pain but tolerable.
3=**Moderate**. Aggravating but still allows movement.
4=**Strong Pain**. Aggravating with minimal movement.
5=**Severe Pain**. Unbearable and no movement.

3) Please **Circle** the health concern(s) you may be experiencing now or have had in the past. Each area of concern relates to an area of the spine and fuction of the nerves.

C1	Headaches
C2	Migraines
C3	Dizziness
C4	Sinus Problems
	Allergies
	Fatigue
C5	Head Colds
C6	Vision Problems
C7	Difficulty Concentrating
T1	Hearing Problems
T2	Mid Back Pain
T3	Congestion
T4	Difficulty Breathing
T5	Bronchitis
T6	Pneumonia
T7	Gallbladder Conditions
T8	Stomach Problems/Ulcers
T9	Gastritis
	Kidney Conditions
L1	Constipation
L2	Colitis
L3	Diarrhea
L4	Gas Pain
L5	Irritable Bowel
S	Bladder Conditions
A	Menstrual Conditions
C	Low Back Pain
R	Pain or Numbness in Low Back
A	Reproductive Conditions
L	

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Health Goals

Check any of your health goals:

○ Improve Nutrition/Eating Habits ○ Increase Lean Muscle Mass ○ Start Exercising ○ Improve Energy

○ Weight Loss/Fat Loss ○ Reduce Stress ○ Improve Sleep ○ Reduce Pain

○ Improving Movement/flexibility ○ Lower Cholesterol/Blood Pressue ○ Improve Posture ○ Other:_____

Last Name, First Name:

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosure for the purposes of treatment, payment, or practice of care will be made only after obtaining your consent:

1. You may request restrictions on your disclosures.
2. You may inspect and receive copies of your records within 30 days of a request.
3. You may request to view changes to your records
4. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
2. *Obtain payment from third party payers.*
3. *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that I can restrict how my personal information is used or disclosed.

Patient's Name (please print): Relation to Patient (self/parent/guardian):

Signature: Date:

Terms of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease.

Vertebral subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any question regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature: Date:

Witness' Signature: Date:

Last Name, First Name:

Payment Agreement/Use of Insurance Authorization

I hereby authorize the Doctors of Breath of Life Chiropractic to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered by me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Breath of Life Chiropractic will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered by me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Breath of Life Chiropractic for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Breath of Life Chiropractic will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Breath of Life Chiropractic will be credited to my account upon receipt.

Signature: Date:

Guardian/Authorized Person of Care Signature: Date:

Who should receive bills for payment on your account?

○ Patient ○ Spouse ○ Parent ○ Workers Comp ○ Auto Insurance ○ Medicare ○ Health Insurance

Date of Birth:

Insurance Company: ID# Group ID:

Authorization For Care Of a Minor

I hereby authorize the doctors in the chiropractic office and whomever they may designate as their assistant to administer chiropractic care to my child through the use of adjustments and procedures the doctor deems appropriate such as mobility, massage, and any therapy the doctor seems appropriate as discussed with parent. I clearly understand and agree that all services rendered by my child are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Dr. Kyle Denholm of Breath of Life Chiropractic will not be held responsible for any pre-existing medically diagnosed condition or for any medical diagnosis. I also understand if I suspend or terminate my child's care for any reason, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my child's insurance rights and benefits (if applicable) directly to the provider for services rendered. I authorize the use of this signature to allow the insurance company to pay Breath of Life Chiropractic directly any amount payable as my child's assignment of benefits. I authorize the use of this signature on any insurance submissions.

Name of Child:

Parent or Guardian Authorizing Care's Name (please print): Birthdate:

Signature of Parent or Guardian: Date:

X-ray Consent

I hereby give my consent to Breath of Life Chiropractic and it's representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

Patient Signature: Date:

Last Name, First Name:

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:	Relationship:
Address:	
Phone:	

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

1. A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
2. B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
    1. Mental health records
    2. Communicable diseases (including HIV and AIDS)
    3. Alcohol/drug abuse treatment
    4. Other (please specify):
    5. _____
    6. _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

1. An electronic record or access through an online portal
2. Hard copy

This authorization shall be effective until (Check one):

1. All past, present, and future periods, OR
2. Date or event:_____
   unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Name of Individual Giving this Authorization (please print):	Date of Birth:
Signature of Individual Giving this Authorization:	Date:

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the **past 30 days**:

0 = Never have this symptom
1 = Rarely have this symptom, effect not severe
2 = Occasionally have this symptom, effect is not severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

Head: _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia	**Energy / Activity:** _____ Fatigue / Sluggishness _____ Apathy / Lethargy _____ Hyperactivity _____ Restlessness	**Lungs:** _____ Chest Congestion _____ Asthma, Bronchitis _____ Shortness of Breath _____ Difficulty Breathing
Eyes: _____ Watery or Itchy Eyes _____ Swollen, Red or Sticky Eyelids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (not including near or far sightedness)	**Weight:** _____ Binge Eating / Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight	**Heart:** _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain
Ears: _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage from Ear _____ Ringing in Ears, Hearing Loss	**Emotions:** _____ Mood Swings _____ Anxiety / Fear / Nervousness _____ Anger / Irritability / Aggressiveness _____ Depression	**Digestive Tract:** _____ Nausea, Vomiting _____ Diarrhea _____ Constipation _____ Bloated Feeling _____ Belching, Passing Gas _____ Heartburn _____ Intestinal / Stomach Pain
Nose: _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus Formation	**Mind:** _____ Poor Memory _____ Confusion, Poor Comprehension _____ Poor Concentration _____ Poor Physical Condition _____ Difficulty Making Decisions _____ Stuttering or Stammering _____ Slurred Speech	**Mouth and Throat:** _____ Chronic Coughing _____ Frequent Need to Clear Throat _____ Sore Throat, Hoarseness _____ Swollen or Discolored Tongue _____ Canker Sores
Skin: _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating	**Joints / Muscles:** _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limited Movement _____ Pain or Aches in Muscles _____ Weakness or Fatigued Muscles	**Other:** _____ Frequent Illness _____ Frequent or Urgent Urination _____ Genital Itch or Discharge

Last Name, First Name:

Protecting Your Confidential Health Information is Important to Us

HIPPA Notice of Privacy Practices

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

Dear Patient:

This is not meant to alarm you! It is our desire to communicate to you that we are taking the Federal (HIPAA- Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why a privacy policy?

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures, which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal laws regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing our treatment; obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USED:

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing your treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunity use clinical situations experienced by patients receiving care at our office. As a result health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routing processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interests to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, letters, telephone reminders or email reminders (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating I providing your care.

To Coroners, Funeral Directors and Medication Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval, and of an Institutional Review Board.

Authorization to Use of Disclose Health Information

Other than is stated above or where Federal State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

This new law is careful to describe that you have the following rights related to your health information

Restrictions - **You have the right** to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications - **You have the right** to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members preset or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information - **You have the right** to read, review, and copy your health information, including your complete chart, x- rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information - **You have the right** to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information - **You have the right** to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment, or health operations. Our documentation procedures will enable us to provide information on health information usage from June 1, 2009 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice - **You have the right** to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative the Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Acknowledgement: *Thank you very much for taking time to review how we are using your health information. If you have any questions, please let us know. If not, please acknowledge your receipt of our policy by signing below. Thank you!*

Patient Name: (please print)	Name of Guardian if signing for Minor:
Patient/Guardian Signature:	Date: