HUNGERFORD
CHIROPRACTIC & PHYSICAL THERAPY

NEW PATIENT INFORMATION SHEET

PATIENT

Last Name: _____ First Name: _____ Middle Initial: ____

Gender: M F Date of Birth: ___/___/___ Age: ___ SS#: _____ How many children?____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Ph: (___)_____ Cell Ph: (___)_____ Work Ph: (___)_____

Employer Name: _____ Occupation: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____@_____

☐ Please check here if you agree with email notifications to the specified email address listed above for appt. reminders. Please also note, we will not send you junk mail or pass on your email address to anyone else.

SPOUSE or GUARDIAN

Last Name: _____ First Name: _____ Middle Initial: ____

Employer Name: _____ Work Phone: _____

EMERGENCY *(Name and address of the nearest relative or friend not living with you)*

Last Name: _____ First Name: _____ Middle Initial: ____

Home Phone # (_____)_____ Work Phone # (_____)_____

Relationship to Patient: _____

INSURANCE

Primary Insurance Company: _____

Insured's Name: _____ Insured Date of Birth: ____/____/____

Secondary Insurance Company: _____

Insured's Name: _____ Insured Date of Birth: ____/____/____

RESPONSIBLE PARTY *(Complete this section if someone other than the patient is responsible for the bill.)*

Responsible Party: _____ Relationship to Patient: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone # (_____)_____ Work Phone # (_____)_____

Employer Name: _____ Occupation: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

Is this condition due to an injury arising out of employment? Yes No

Is this condition due to an injury arising out of an auto accident? Yes No

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Patient Health Questionnaire

Patient Name: _____ **Date:** _____

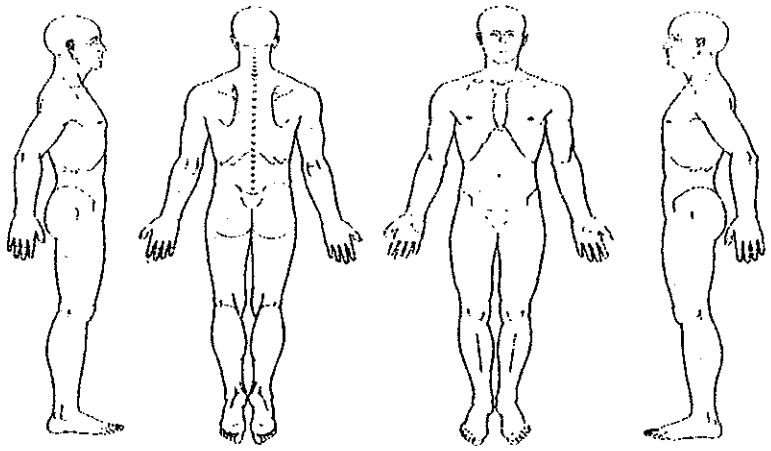
1. **Describe your symptoms and how they began:** _____

_____

2. **Have you ever received chiropractic treatment for any condition in the past?** Yes No

3. **When did your symptoms start?** _____

4. **Indicate below on diagram where you have pain or other symptoms:**



5. **How often do you experience your symptoms?**
   - ○ Constantly *(76-100% of the day)*
   - ○ Frequently *(51-75% of the day)*
   - ○ Occasionally *(26-50% of the day)*
   - ○ Intermittently *(0-25% of the day)*

6. **What describes the nature of your symptoms?**
   - ○ Sharp
   - ○ Dull Ache
   - ○ Numb
   - ○ Shooting
   - ○ Burning
   - ○ Tingling

7. **How are your symptoms changing?**
   - ○ Getting Better
   - ○ Not Changing
   - ○ Getting Worse

8. **How bad are your symptoms**

	No Pain										Unbearable
at their best:	0	1	2	3	4	5	6	7	8	9	10
	No Pain										**Unbearable**
at their worst:	0	1	2	3	4	5	6	7	8	9	10

Patient Health Questionnaire (cont.)

9. **What activities make your symptoms worse:** _____

10. **What activities make your symptoms better:** _____

11. **Who have you seen for your current symptoms?** _____

12. **Who is your primary medical physician?** _____

13. **Have you had similar symptoms in the past?** Yes No

a. What tests have you had for your symptoms in the past?

Xrays date: _____ MRI date: _____ CT Scan date: _____ Other date: _____

14. **What is your:** **Height:** _____ Feet _____ Inches **Weight:** _____ lbs.

15. **List all the surgical procedures you have had and times you have been hospitalized:**

_____

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	*Present*		*Past*	*Present*		*Past*	*Present*	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Asthma
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Chronic Sinusitis
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Smoking/Use Tobacco Products
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Drug/Alcohol Dependence
☐	☐	Low Back Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Shoulder Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Elbow/Upper Arm Pain	☐	☐	Bladder Infection			
☐	☐	Wrist Pain	☐	☐	Painful Urination			***Females Only***
☐	☐	Hand Pain	☐	☐	Loss of Bladder Control	☐	☐	Birth Control Pills
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Hormonal Replacement
☐	☐	Knee/Lower Leg Pain	☐	☐	Abnormal Weight Gain/Loss	☐	☐	Pregnancy
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite	☐	☐	
☐	☐	Jaw Pain	☐	☐	Liver/Gall Bladder Disorder			***Other Health Problems/Issues***
☐	☐	Arthritis	☐	☐	Cancer	☐	☐	
☐	☐	Rheumatoid Arthritis	☐	☐	Tumor	☐	☐	
☐	☐	General Fatigue	☐	☐	Dizziness	☐	☐	

Patient Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program.

Name:_____ **Gender (Circle one):** M / F **DOB:** ___/___/___

Email address:_____ **Preferred Language:**_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American
White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter meds)

Medication Name	Dosage

Medication Name	Dosage

Do you have any medication allergies?

Medication Name	Reaction	Onset Date

Family Health History (Please list any diagnosed disease, disorder, or syndrome for the following family members. For example: High Blood Pressure, Diabetes, Heart Disease, Cancer, etc. Leave blank if there is no history of illness.)

Father	
Mother	
Sister	
Brother	
Daughter	
Son	

☐ **I choose to decline receipt of my clinical summary after every visit.** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature:_____ **Date:**_____

☐ **For office use only**

Height: Weight: Blood Pressure: /

CONSENT TO USE & DISCLOSE HEALTH INFORMATION (2014)

18 Years of Age and Older

Hungerford Chiropractic and Physical Therapy

This office is required by Federal Regulations to inform our Patients in regards to the use of your child's health information in accordance to Health Insurance Portability & Accountability Act of 1996 or HIPAA.

I understand that as part of my health care, Hungerford Chiropractic and Physical Therapy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party can verify the services billed to me actually took place.

I understand and have been provided access to a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. This notice is located in the waiting area in plain view. I understand that I have the following rights and privileges:

- The right to review the *Notice of Privacy Practices* prior to signing this consent, allowing treatment, or making payment for services rendered and the right to a paper copy of the Notice of Privacy Practices
- The right to object to the use of my health information for directory purposes
- The right to request special privacy protections
- The right to request confidential communications
- The right to inspect and copy
- The right to amend or supplement
- The right to an accounting of disclosures

I understand that Hungerford Chiropractic and Physical Therapy is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization may refuse to treat me as permitted by Federal Regulations.

I understand that Hungerford Chiropractic and Physical Therapy reserve the right to change their *Notice of Privacy Practices.*

I authorize the following individuals listed below access to my medical information from Hungerford Chiropractic and Physical Therapy or to discuss my medical information with Hungerford Chiropractic and Physical Therapy and its physicians (please print all names below).

Full Name _____ Relationship _____

Full Name _____ Relationship _____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax. I further understand that I may revoke this consent at any time and I must notify Hungerford Chiropractic and Physical Therapy in writing in order to revoke the consent.

I fully understand and accept the terms of this consent.

Signature _____ **Date** _____

Print Name _____ **Date of Birth** _____

REVOKE CONSENT

(do not sign below unless you are revoking the above consent)

I hereby revoke the above consent effective immediately. I understand that revoking this consent means that my medical information and protected health information will no longer be discussed or disclosed (released) to the above individuals and that a new consent will need to be completed if this changes.

Signature of Patient _____ Date signed _____

Updated 5.20.14