DR LARRY MCCOY * 176 THOMPSON LN. STE G-1, NASHVILLE, TN 37211 * (615) 739-5047

Patient Profile

Full Name: ____
Last First MI

Birthdate: _____/______/______ Social Security*: ______-_____-_______
mm dd yy *Medicare Patients Only

Address: ________________________________ ____________
Street Address Apt/Unit

______________________ __________ ____________
City State Zip Code

Primary Phone: ____________ H / C / B Secondary Phone: ____________ H / C / B

Emergency Contact: ____
Name Phone

Email Address: ________________________ Referred By: ______________

Marital Status: Single Married Widowed Divorced

Occupation: __________________________

Do you have health insurance? No Yes Insurance Company: ______________
Responsible party: Self Other If other, list name: ______________

Do you have a health savings account/health reimbursement account? No Yes

Chief Complaint Form

Reason for your visit: ____
____
____

When did the symptoms begin: ____________________
mm/dd/yy

Have you previously been treated by a chiropractor? No Yes If yes: For your current symptom? ___________
When was the treatment? ___________

Which word describes the frequency of your discomfort?

- ☐ Constant ☐ Intermittent ☐ Frequent ☐ Occasional

When is the pain the worst?

- ☐ Morning ☐ Afternoon ☐ Night ☐ Changes in weather ☐ No change

What helps relieve the pain?

- ☐ Medication ☐ Heat ☐ Ice ☐ Nothing helps ☐ Other: __________

Which phrases best describe changes in your discomfort during the day? select all that apply

☐ Bending	☐ Getting up	☐ Reading	☐ Turning head
☐ Bowel Movement	☐ Lifting	☐ Sitting	☐ Urination
☐ Coughing	☐ Lying down	☐ Sleeping	☐ Walking
☐ Daily routine	☐ Pulling	☐ Sneezing	☐ Working
☐ Driving	☐ Pushing	☐ Standing	☐ __________

Approximate date of your most recent: (mm/yy)

CT Scan: ___________ MRI: ___________ Spinal X-ray: ___________

Health History

List prescriptions, over-the-counter medicines, vitamins or supplements you currently take:

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Do you:

Smoke? ☐ Everyday smoker ☐ Some day smoker

☐ Former smoker ☐ Never smoker

Drink alcohol? ☐ No ☐ Yes Drinks per week:______

Exercise? ☐ No ☐ Yes Times per week:______

Allergies? ☐ No ☐ Yes Please list:____________________

List any surgeries and approximate date:

____________________ ____________________

____________________ ____________________

____________________ ____________________

List any implants, screws, plates, or other foreign objects in your body:

____

Has a physician ever diagnosed you with cancer? ☐ No ☐ Yes List kind:__________

<u>For Women Only</u>

Most recent menstrual cycle:__________________
mm/dd/yy

Are you pregnant? ☐ No ☐ Yes

Have you given birth? ☐ No ☐ Yes How many times_________

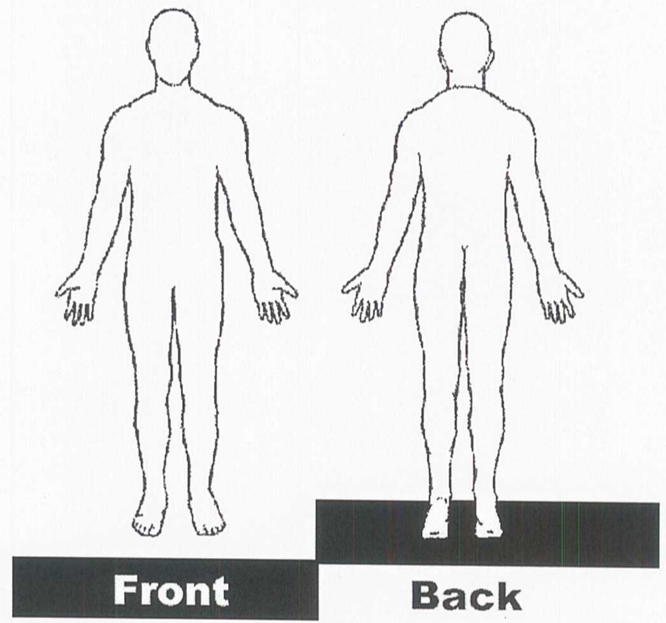
Health History

Do you currently or have you previously had any of the following symptoms?

Currently Have Condition	Previously Had Condition	Symptom	Currently Have Condition	Previously Had Condition	Symptom	Currently Have Condition	Previously Had Condition	Symptom
☐	☐	Pacemaker	☐	☐	Loss of Smell	☐	☐	Sleep Problems
☐	☐	Headaches	☐	☐	Loss of Taste	☐	☐	Sinus Problems
☐	☐	Neck Pain	☐	☐	Loss of Balance	☐	☐	Cold Sweats
☐	☐	Stiff Neck	☐	☐	Buzzing in Ears	☐	☐	Stomach Upset
☐	☐	Back Pain	☐	☐	Ringing in Ears	☐	☐	Frequent Colds
☐	☐	Tension	☐	☐	Feet/hands Cold	☐	☐	Shortness of Breath
☐	☐	Muscle Spasms	☐	☐	Sudden Weight Loss	☐	☐	Dizziness
☐	☐	Neck/arm Pain	☐	☐	Arthritis	☐	☐	Nervousness
☐	☐	Tingling in Arms	☐	☐	Swelling Joints	☐	☐	Depression
☐	☐	Tingling in Legs	☐	☐	Shoulder Pain	☐	☐	Difficulty Urinating
☐	☐	Numbness in Fingers	☐	☐	Knee Pain	☐	☐	Fatigue
☐	☐	Numbness in Toes	☐	☐	Leg Cramps	☐	☐	Diabetes
☐	☐	Weakness in Arms	☐	☐	Fever	☐	☐	High Blood Pressure
☐	☐	Weakness in Legs						

Patient System Illustrator

To help us understand your symptoms, identify your areas of discomfort using the illustration and creating a description.



Instructions:

1. Using diagram (left), circle affected body part(s).
2. Using table (below), describe pain in affected area.
3. Using scale (below), rate the severity of pain in affected area.

1) Affected Body Part: ____________________ Affected Side: Left Right

Symptom(s): ☐ Burning ☐ Dull Ache ☐ Sharp Stabbing ☐ Throbbing ☐ Numbness ☐ Pins & Needles ☐ Spasms ☐ Swelling ☐ Stiffness

Severity of pain: 1 2 3 4 5 6 7 8 9 10

2) Affected Body Part: ____________________ Affected Side: Left Right

Symptom(s): ☐ Burning ☐ Dull Ache ☐ Sharp Stabbing ☐ Throbbing ☐ Numbness ☐ Pins & Needles ☐ Spasms ☐ Swelling ☐ Stiffness

Severity of pain: 1 2 3 4 5 6 7 8 9 10

3) Affected Body Part: ____________________ Affected Side: Left Right

Symptom(s): ☐ Burning ☐ Dull Ache ☐ Sharp Stabbing ☐ Throbbing ☐ Numbness ☐ Pins & Needles ☐ Spasms ☐ Swelling ☐ Stiffness

Severity of pain: 1 2 3 4 5 6 7 8 9 10

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _____

Consent to Perform and Interpret X-rays The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

Assignment of Benefits and Release of Records The patient hereby assigns benefits to be paid directly to this provider by all of the third party payors. This assignment is irrevocable. Failure to fill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation and Appointment Policy The patient accepts full financial responsibility for services rendered by this practice. An account which is past due and for which no payment arrangements have been made will be forwarded to a collection agency. Collection agency fees will be the responsibility of the patient.

Initial _____

______________________	______________________	____________
Print Name	Signature	Date