NEW PATIENT INFORMATION

PLEASE PRINT CLEARLY

Today's Date____/____/20___ **Date of Birth**____/____/____

Full Name:_____Email:_____Gender □F □M
Address_____City:_____State_____Zip____
Social Security #:____-____-_____ Driver's License #:_____Home Phone#_____
Marital Status: □S □M □D □W # of Children____ Cell Phone#_____
Last Menstrual Period:_____ Pregnant? □Y □N Nursing? □Y □N Work Phone#_____
Work Status: □FT □PT □Retired/Student
Employer_____Occupation_____
Employer Address_____City_____State____Zip_____

Spouse/Parent/Guardian_____ Birth Date_____ SS#:____-____-_____
Employer_____Occupation_____ Work Phone#_____
Home Phone#_____ Cell Phone #_____

In Case of an Emergency Contact: _____ Relationship:_____
Home Phone#_____ Cell Phone #_____ Work Phone#_____
Name of Medical Physician_____
How did you hear about us? Whom may we thank for referring you?:_____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

- **The patient understands and agrees to allow Idaho Chiropractic Group to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.**
- **The patient has the right to examine and obtain a copy of his/her own 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. Our office is not obligated to agree to those restrictions.**
- **A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.**
- **The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.**
- **For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Idaho Chiropractic Group to assure that your records are not readily available to those who do not need them.**
- **Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.**
- **If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.**

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____
Print Patient Name

_____
Patient/Parent/Guardian Signature

SURGICAL PROCEDURES:

_____

_____

_____

TREATMENT: *What type of treatment are you looking for?*

□ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
□ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
□ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

COMPLAINT/PROBLEM: *In relation to your primary complaint*:

When did you first seek treatment for this problem?_____ Has another doctor(s) treated you for this condition: □Y □N
If yes, whom?_____Treatment(s):_____
Have you had any intolerance or reactions to treatments? □Y □N Describe:_____

If this is a recurrence, when was the first time you noticed this problem?_____

How did it originally occur? _____*Has it become worse recently*? □Y □N □ Same □ Better □ Gradually Worse

How frequent is the condition? □ Constant □ Daily □ Intermittent □ Night Only

How long does it last? □ All day □ Few hours □ Minutes

Is this condition interfering with your: □ Work □Sleep □ Daily routine □ Recreation □ Other:_____

How long has it been since you really felt good? □ Days □ Weeks □ Months □Years □>10 years

What makes the problem worse? □ Standing □ Sitting □ Lying □ Bending □ Lifting □ Twisting □ Other:_____

Is there anything that you can do to relieve the problem? □ Y □ N If yes, describe:_____

If no, what have you tried to do that has not helped?_____

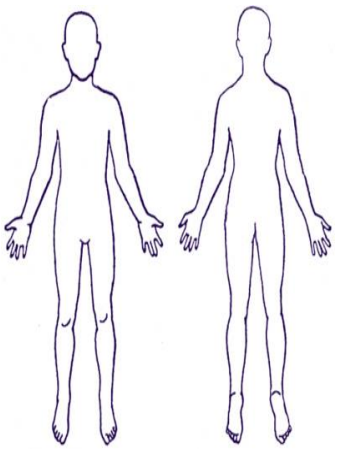
Are there any other conditions or symptoms that may be related to your major symptom? □Y □N If yes, what?_____
Have you been in an auto accident? □ Past year □ Past 5 years □ Over 5 years □ Never
Describe:_____

Please check all of the symptoms that apply. (P=Past/ C=Current)

P/C	P/C	P/C
□ □ Headache	□ □ High Blood Pressure	□ □ Tingling in Feet
□ □ Facial Pain	□ □ Low Blood Pressure	□ □ Walking Problems
□ □ Eye Pain	□ □ Abdominal Pains	□ □ Sore Muscles
□ □ Blurred Vision	□ □ Nausea/Vomiting	□ □ Weak Muscles
□ □ Dizziness	□ □ Poor Appetite	□ □ Paralysis
□ □ Earache	□ □ Fullness of Bladder	□ □ Shakiness
□ □ Forgetfulness	□ □ Urination Difficulty	□ □ Sweating
□ □ Confusion	□ □ Frequent Urination	□ □ Insomnia
□ □ Sinusitis	□ □ Constipation	□ □ Fainting
□ □ Teeth Grinding	□ □ Hemorrhoids	□ □ Convulsions
□ □ Dry Mouth	□ □ Decreased Sex Drive	□ □ Irritability
□ □ Excessive Thirst	□ □ Menstrual Irregularities	□ □ Impatience
□ □ Unpleasant Taste	□ □ Elbow/Hand Pain	□ □ Fatigue
□ □ Neck Pain	□ □ Tingling in Hands	□ □ Feel Loss of Control
□ □ Sore Throat	□ □ Clammy Hands	□ □ Other:_____
□ □ Lump in Throat	□ □ Low Back Pain	_____
□ □ Swallowing Pain	□ □ Hip Pain	
□ □ Unsteady Voice	□ □ Knee Pain	
□ □ Shoulder Pain	□ □ Poor Circulation	
□ □ Persistent Coughing	□ □ Swollen Joints	
□ □ Chest Pressure	□ □ Joint Stiffness	
□ □ Slow Heart Rate	□ □ Swollen Ankles	
□ □ Rapid Heart Rate	□ □ Ankle/Foot Pain	

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing/Cutting-///	Tingling-:::
Burning-XXX	Cramping-^^^
Numbness-===	Dull-###



HABITS:	Heavy	Moderate	Light	None
Alcohol	□	□	□	□
Coffee	□	□	□	□
Soda/Diet Soda	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Stress Level	□	□	□	□

	5-7x/wk	3-5x/wk	1-3x/wk	None
Exercise	□	□	□	□
	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs
Sleep	□	□	□	□
	5+	4	3	2
Meals/Day	□	□	□	□
	64+ oz	32-64 oz	16-32 oz	<8 oz
Water/Day	□	□	□	□

Type	Time
_____	_____
<5 hrs	
□	

WORK ACTIVITY: □ Heavy Labor □ Light Labor □ Mostly Sitting □ Mostly Standing □ Walking/Moving □ Driving

FAMILY HISTORY: *Identify any conditions that you, or any of your family members have now or have had in the past:*
*(**G**=Grandparents, **M**=Mother, **F**=Father, **S**=Siblings, **X**=Self)*

____Alcoholism	____Eczema	____Miscarriage	____Tumor(s)
____Anemia	____Emphysema	____Mumps	____Ulcer(s)
____Cancer	____Epilepsy	____Pleurisy	____Other:_____
____Cold sores	____Goiter	____Pneumonia	____ _____
____Deep vein thrombosis	____Gout	____Polio	____ _____
____Detached retina	____Heart Disease	____Rheumatic fever	____ _____
____Diabetes	____HIV/AIDS	____Stroke	____ _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION:

_____

_____

_____

HIPPA ACKNOWLEDGEMENT

- I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF Idaho Chiropractic Group, PLLC's Privacy Notice that has an effective date of June 16, 2004. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Idaho Chiropractic Group to assure that your records are not readily available to those who do not need them.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Print Patient Name Date

_____

Patient or Guardian Signature Date