southern maryland
CHIROPRACTIC CENTER

CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Home #: ( ) _____ SS#: _____

Birth Date: _____ Age: _____ Sex: _____

Marital Status: S ☐ M ☐ D ☐ W ☐

# of Children: _____ Referred By: _____

Cell Phone #: ( ) _____

E-Mail Address: _____

Present Family Doctor: _____

EMPLOYMENT INFORMATION

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____

Occupation: _____

Is it all right for our office to contact you at work?

Yes ☐ No ☐

EMERGENCY INFORMATION

Emergency Name: _____

Relationship: _____

Phone #: ( ) _____

ACCOUNT INFORMATION

Person ultimately responsible for account:

(*if different from above*)

Name: _____

SS#: _____

Relation: _____

Billing Address: _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes ☐ No ☐ Date: _____ Type of Accident: Auto ☐ Work ☐ Home ☐ Other ☐

Your Auto/Worker Comp Ins. Co. Name: _____ Address: _____

Other Party's Name: _____ Address: _____

Other Party's Insurance Co.: _____ Address: _____

To whom have you made a report of your accident? Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other ☐

Attorney Name (if applicable): _____

METHOD OF PAYMENT Cash ☐ Insurance ☐ Check ☐ Credit ☐

Our Policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager.

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms to my insurance company or attorney to assist in collecting due fees. If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office.

I authorize the use of this signature on all insurance submissions.

Patient's Signature: _____ Authorizing Guardian Signature: _____ Date: _____

Southern Maryland Chiropractic Center

Patient Name: _____ Date: _____

PAST HEALTH HISTORY

PLEASE LIST ALL SURGERIES YOU HAVE HAD: NONE ☐

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

PLEASE LIST ALL PREVIOUS ACCIDENTS AND FALLS: NONE ☐

What _____ When _____

What _____ When _____

What _____ When _____

PLEASE LIST ALL PREVIOUS FRACTURES AND DISLOCATIONS: NONE ☐

What _____ When _____

What _____ When _____

Remarks _____

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE: NONE ☐

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

PLEASE LIST ANY ALLERGIES (FOOD / MEDICATION): NONE ☐

What _____ What _____

What _____ What _____

OCCUPATIONAL INFORMATION

Occupation _____

Job Involves:

Sitting____ Standing____ How Long?_____ Desk____ Counter____ Other_____

Lifting____ How Much Weight?_____ Bending____ Stopping____ Twisting____ Turning____

Type of Shoes: High Heels____ Boots____ Arch Supports____ Other_____

How long do you speak on the telephone each day? _____ Traditional telephone receiver?____ Headset?____

Physical Activity at Work: Sedentary____ Light Manual Labor____ Manual Labor____ Heavy Manual Labor____

Do any of your work activities aggravate your present main complaints? Please describe _____

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Patient Name: _____ Date: _____

Health Habits: How much per day or week?

Tea/Coffee/Cola_____ Liquor_____ Tobacco_____ Sugar, Candy, Ice Cream_____

Exercise: **1)** Type_____ Frequency_____ **2)** Type_____ Frequency_____

3) Type_____ Frequency_____ **4)** Type_____ Frequency_____

Sleep: Hours per night_____ Type of Mattress_____ Naps_____

Do you sleep on your: Back Side Stomach

Please describe your sleep:_____

Special Diets:_____

THIS IS A CONFIDENTIAL HEALTH REPORT. Please check the appropriate box for any of the following symptoms or conditions which you and/or a family member now have or may have had in the past.

GENERAL	Self	Family
Allergy	___	___
Convulsions	___	___
Dizziness or Fainting	___	___
Headache	___	___
Neuralgia	___	___
Numbness	___	___
Alcoholism	___	___
Cancer	___	___
Polio	___	___
Multiple Sclerosis	___	___
Rheumatic Fever	___	___
Thyroid	___	___
Diabetes	___	___
Other	___	___

MUSCLE & JOINT	Self	Family
Arthritis	___	___
Bursitis	___	___
Foot Trouble	___	___
Low Back Pain	___	___
Neck Pain or Stiffness	___	___
Pain Between Shoulders	___	___
Sciatica	___	___
Swollen Joints	___	___
Pain, Numbness, Cramps	___	___
Shoulders	___	___
Arms	___	___
Elbows	___	___
Hands	___	___
Hips	___	___
Legs	___	___
Knees	___	___
Feet	___	___

OTHER	Self	Family
_____	___	___
_____	___	___
_____	___	___

GASTRO-INTESTINAL	Self	Family
Colon Trouble	___	___
Constipation	___	___
Diarrhea	___	___
Difficult Digestion	___	___
Distension of Abdomen	___	___
Gall Bladder Trouble	___	___
Hemorrhoids	___	___
Liver Trouble	___	___
Pain Over Stomach	___	___
Appendicitis	___	___
Gout	___	___
Ulcers	___	___

EYES, EARS, NOSE, THROAT	Self	Family
Sinus Infections	___	___
Asthma	___	___
Colds	___	___
Deafness	___	___
Earache	___	___
Ear Discharge	___	___
Ear Noises	___	___
Eye Pain	___	___
Nasal Obstruction	___	___
Nosebleeds	___	___

CARDIO-VASCULAR	Self	Family
Hardening of Arteries	___	___
High Blood Pressure	___	___
Low Blood Pressure	___	___
Pain Over Heart	___	___
Poor Circulation	___	___
Rapid Heart Beat	___	___
Slow Heart Beat	___	___
Swelling of Ankles	___	___
Anemia	___	___
Heart Disease	___	___
Stroke	___	___
Aneurism	___	___

RESPIRATORY	Self	Family
Chest Pain	___	___
Chronic Cough	___	___
Difficult Breathing	___	___
Spitting Up Blood	___	___
Wheezing	___	___
Tuberculosis	___	___
Emphysema	___	___

SKIN	Self	Family
Bruise Easily	___	___
Dryness	___	___
Skin Eruptions (rash)	___	___
Varicose Veins	___	___
Eczema	___	___

GENITO-URINARY	Self	Family
Bed-Wetting	___	___
Blood in Urine	___	___
Frequent Urination	___	___
Inability to Control Kidneys	___	___
Kidney Infection or Stones	___	___
Painful Urination	___	___
Prostate Trouble	___	___
Pus in Urine	___	___

FOR WOMEN ONLY	Self	Family
Congested Breasts	___	___
Cramps or Backache	___	___
Excessive Menstrual Flow	___	___
Hot Flashes	___	___
Irregular Cycle	___	___
Lumps in Breast	___	___
Menopausal Symptoms	___	___
Painful Menstruation	___	___
Vaginal Discharge	___	___
Pregnant	Yes	No
Date of Last Period_____		
Previous Miscarriages	Yes	No

DOCTOR'S COMMENTS:

_____

_____

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Patient Name: _____ Patient History Date: _____

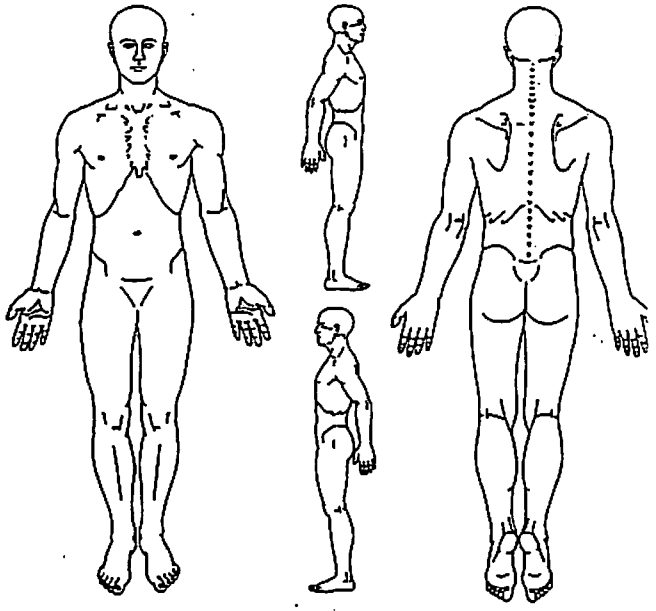
PRESENT REASON FOR CONSULTING THIS OFFICE: **check box below** ☐

- ☐ I have no special problem; I understand the role of Chiropractic and Wellness in my general health care.
- ☐ I have a symptom and I am interested in help with this specific problem; in addition, I am interested in learning about my Health Potential and the role of "Wellness" in improving my family's health.
- ☐ I have a symptom and I am interested in help with this problem; and in learning how to **PREVENT** it in the future.
- ☐ I have a symptom and I am only interested in help with this specific problem.

COMPLAINT(S): List your areas of complaint individually, in order of severity

#1 _____

Please mark your areas of pain on the figures below:



Date when symptom first appeared _____

How often do you experience the symptoms?

_____Constant **100%** _____ Frequent **75%**

_____ Intermittent **50%** _____Occasional **25%** _____ Rare **10%**

Is this related to an accident of fall? _____Yes _____No

Describe: _____

_____

Is this condition getting progressively worse? _____Yes _____ No

What makes symptoms increase? _____

What gives relief of symptom? _____

Type of pain: _____Sharp _____Dull _____Throbbing

_____ Numbness _____ Aching _____ Shooting

_____ Stiffness _____ Swelling _____ Tingling _____ Cramps

Does it interfere with your: _____Work _____ Sleep

_____Daily Routine _____ Recreation

Activities or movements that are painful to perform: _____ Lying Down

_____ Standing _____ Walking _____Bending _____Sitting

Does the pain radiate? _____ Yes _____No Where? _____

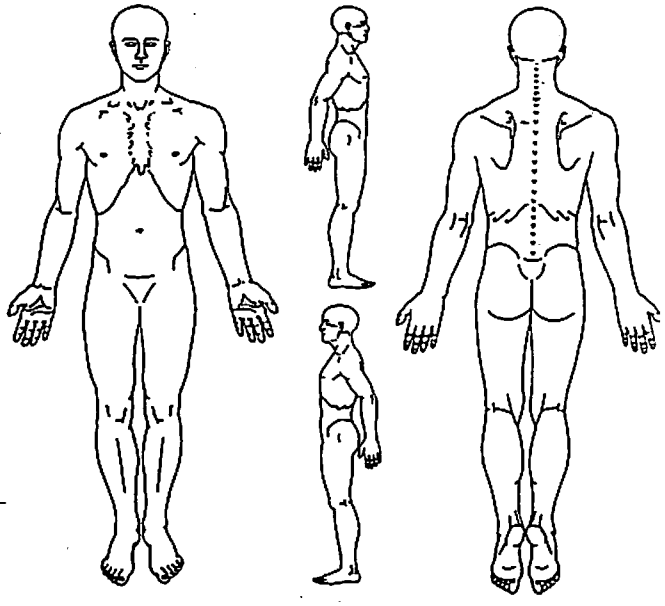
How bad is your pain? ***(Indicate by placing an "X" on scale below)***

0 ——|——|——|——|——5——|——|——|——|—— 10

No Pain Extreme Pain

#2 _____

Please mark your areas of pain on the figures below:



Date when symptom first appeared _____

How often do you experience the symptoms?

_____Constant **100%** _____ Frequent **75%**

_____ Intermittent **50%** _____Occasional **25%** _____ Rare **10%**

Is this related to an accident of fall? _____Yes _____No

Describe: _____

_____

Is this condition getting progressively worse? _____Yes _____ No

What makes symptoms increase? _____

What gives relief of symptom? _____

Type of pain: _____Sharp _____Dull _____Throbbing

_____ Numbness _____ Aching _____ Shooting

_____ Stiffness _____ Swelling _____ Tingling _____ Cramps

Does it interfere with your: _____Work _____ Sleep

_____Daily Routine _____ Recreation

Activities or movements that are painful to perform: _____ Lying Down

_____ Standing _____ Walking _____Bending _____Sitting

Does the pain radiate? _____ Yes _____No Where? _____

How bad is your pain? ***(Indicate by placing an "X" on scale below)***

0 ——|——|——|——|—— 5 ——|——|——|——|—— 10

No Pain Extreme Pain

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care we must require you to 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 Patient Health Information we encourage you to read the HIPPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or 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.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect 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.
5. 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 this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. 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.

_____ _____

Name of Patient: (print & sign) Date:

3450 Old Washington Road, Ste 101, Waldorf, Maryland 20602