CONFIDENTIAL PATIENT HEALTH RECORD

Today's Date: _____ Email Address: _____

Name: _____Middle: _____ Last: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Date of Birth (M/D/Y): _____ Sex: **M F** Marital Status: **S M W D DP LS**

[ ] Yes, you may contact me via email and text message.

Your Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Name of Significant Other: _____ Significant Other Date of Birth: _____

Number of Children: ____ Names of Children and Ages: _____

Name of Family Doctor: _____ Doctor Phone: _____

Whom may we thank for referring you to our office? _____

Have you ever received chiropractic care? **Yes No** Date of last visit: _____

Chiropractor: _____ Is this a Worker's Compensation case? **Yes No**

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

CURRENT HEALTH CONDITION:

Describe the major complaint(s)/reason(s) that bring you to our office: _____

_____

_____

When did this start? _____ Have you had this before? **Y N**

What do you feel caused this problem? _____

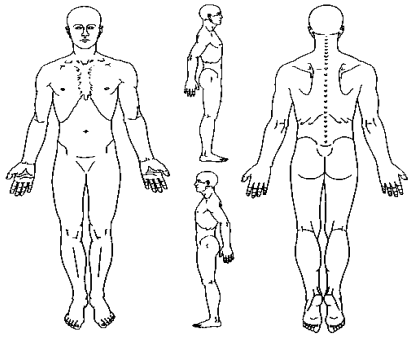
Type: **Pain Numbness Swelling Muscle Spasms Headache Tightness Stiffness Tingling Weakness**

Quality: **Sharp Dull Aching Throbbing Crushing Stabbing Local Radiating Burning**

Migraine Tension Hormonal Sinus Organic

On a scale of 1-10 circle the number that represents the severity of your pain:	
NO PAIN	**0**
MILD PAIN	**1 2 3**
MODERATE PAIN	**4 5 6**
SEVERE PAIN	**7 8 9**
DISABLING PAIN	**10**

Indicate where your pain is located with an "X":



Is the Pain: **Constant Frequent Intermittent Occasional Infrequent**

What activities make your condition/pain better? _____

Is this condition worse during certain times of the day? **Yes No** When? **AM PM NIGHT**

Is this condition getting progressively worse? **Yes No**

Have you seen anyone else for this? **Yes No** Who? _____

Explain previous and current care for this problem: _____

_____

Are you taking any medications for this problem? **Yes No** Which one(s)? _____

DAILY ACTIVITIES:

Bending	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Carrying	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Climbing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Concentrating	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Dancing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Doing Chores	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Doing Computer Work	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Dressing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Driving	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Gardening	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Lifting	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Performing Sexual Activity	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Playing Sports	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Pushing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Reading	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform

Recreating	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Rolling Over	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Running	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Shoveling	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Sitting	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Sitting to Stand	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Sleeping	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Standing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Walking	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Watching TV	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Working	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform

Please list drugs that you currently take: _____

_____

FAMILY HEALTH HISTORY:

Does any member of your family suffer from your current condition? **Yes No** Whom? _____

Any other pertinent family history/conditions: _____

Is there a family history of: **Heart Disease Cancer Arthritis Diabetes Other:**_____

HEALTH SURVEY:

For the following conditions, please circle **O** for previously had or **Δ** for currently have…

Cardiovascular

O Δ Bleeding Disorders	O Δ Irregular Heart Beat	O Δ Stroke
O Δ High Blood Pressure	O Δ Pain/Pressure in Chest	O Δ Heart Attack
O Δ Low Blood Pressure	O Δ Short Breath with Exertion	O Δ Heart Disease
O Δ High Cholesterol	O Δ Prolapsed Valve	O Δ Pacemaker

Eyes, Ears, Nose, Throat

O Δ Dental Problems	O Δ Ringing in Ears	O Δ Nose Bleeds
O Δ Difficult Breathing	O Δ Vision Problems	O Δ Ear Pain
O Δ Difficult Speech	O Δ Hearing Loss	O Δ Cataracts
O Δ Glaucoma	O Δ Eyes Sensitive to Light	O Δ Tonsillitis
O Δ Head Injuries	O Δ Loss of Taste	O Δ Dizziness
O Δ Loss of Balance	O Δ Loss of Memory	O Δ Loss of Smell

Immune

O Δ Catch Colds Easily	O Δ Frequent Influenza	O Δ AIDS/HIV
O Δ Sinus Troubles	O Δ Mononucleosis	O Δ Allergies

Respiratory

O Δ Chronic Cough
O Δ Asthma
O Δ Coughing Blood
O Δ Bronchitis
O Δ Pneumonia
O Δ Emphysema

Gastrointestinal

O Δ Mucous in Stool
O Δ Liver Disease
O Δ Burping, Bloating
O Δ Colitis
O Δ Constipation
O Δ Diarrhea
O Δ Celiac Disease
O Δ Gallbladder Problems
O Δ Pain in Stomach
O Δ Hernia
O Δ Reflux
O Δ Anorexia/Bulimia
O Δ Blood in Stool
O Δ Nausea
O Δ Heartburn
O Δ Weight Gain
O Δ Weight Loss
O Δ Vomiting

General

O Δ Rheumatoid Arthritis
O Δ Anemia
O Δ Cancer
O Δ Parkinson's
O Δ Depression
O Δ Diabetes
O Δ Epilepsy
O Δ Sleeping Problems
O Δ Appendicitis
O Δ Gout
O Δ Migraines
O Δ Psychiatric Care
O Δ Hypoglycemia
O Δ Multiple Sclerosis
O Δ Thyroid Problems
O Δ Tuberculosis
O Δ Prosthesis
O Δ Joint Replacement
O Δ Rheumatic Fever
O Δ Suicide Attempt
O Δ Chemical Dependency
O Δ Tumors, Growths
O Δ Rheumatic Fever
O Δ Fainting
O Δ Skin Problems
O Δ Irritability
O Δ Nervousness
O Δ Ulcers
O Δ Polio
O Δ Arthritis
O Δ Dislocations
O Δ Broken Bones
O Δ Hepatitis
O Δ Osteoporosis

Urinary

O Δ Blood in Urine
O Δ Kidney Stones
O Δ Inability to Control
O Δ Kidney Disease
O Δ Painful Urination
O Δ Bed Wetting

Neuromuscular Skeletal

O Δ Headaches
O Δ Tingling in Hands/Feet
O Δ Herniated Disc
O Δ Numbness in Fingers/Toes
O Δ Neck Pain
O Δ Pain in Leg(s)
O Δ Pinched Nerves
O Δ Tension
O Δ Low Back Pain
O Δ Pain in Arm(s)
O Δ Stiff Neck

TO BE COMPLETED BY WOMEN ONLY

O Δ Excessive Flow
O Δ Headaches with Periods
O Δ Hot Flashes
O Δ Premenstrual Depression
O Δ Irregular Periods
O Δ Lumps in Breasts
O Δ Menstrual Cramps
O Δ Miscarriage
O Δ Painful Breasts
O Δ Vaginal Discharge
O Δ Hysterectomy
O Δ Vaginal Infections

TO BE COMPLETED BY MEN ONLY

O Δ Burning Urination
O Δ Difficulty Starting Flow
O Δ Dripping After Urination
O Δ Feeling of Incomplete Evacuation
O Δ Frequent Urination at Night
O Δ Prostate Problems

Patient Signature: _____ **Date:** _____

Examiner Signature: _____ **Date:**_____

PAYMENT INFORMATION RECORD

Patient Name: _____

Date of Birth (M/D/Y): _____

Please check one:

[ ] Yes, I have insurance that I would like verified. I am providing Focused on You Chiropractic with my insurance information.

[ ] No, I do not have any insurance that I would like verified.

Subscriber's First Name: _____ Last Name: _____

Subscriber's Date of Birth (M/D/Y): _____

Subscriber's Employer: _____Occupation: _____

Work Address: _____ City: _____

State: _____ Zip Code: _____ Work Phone: _____

Insurance Co: _____ Phone Number: _____

Address: _____

Group Number: _____ Policy Number: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Secondary Insurance Co: _____ Phone Number: _____
Address: _____

Group Number: _____ Policy Number: _____

Who is responsible for this account? _____ Relationship to Patient: _____

ASSIGNMENT OF BENEFITS AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance companies listed above and assign directly to **Focused On You Chiropractic L.L.P.C.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Focused On You Chiropractic L.L.P.C.** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date: _____

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic at Focused On You Chiropractic or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor Focused On You Chiropractic, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic at Focused On You Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____
Signature of Patient or Guardian:_____
Date:_____

Printed Name of Guardian and Relationship:_____

Focused On You Chiropractic – Office Procedures & Policies

The purpose of this form is to allow us to more completely serve you so you can get the best results in the shortest amount of time.

□ UPON ARRIVAL

When you arrive, we ask that you turn off all pagers and/or cell phones and leave food or drinks in your vehicles. This will assist us in maintaining a clean, convenient healing atmosphere. Please complete your daily health form, sign and date it. This will give us a detailed record of how you feel your care is progressing. In order to provide the chiropractic care you need as conveniently as possible and with little interruption, please remove all earrings and necklaces, ensure all jackets, coats, and school bags are removed and left in the waiting area on each visit. There are wall hooks that you may hang your items on. If you have any small items, please feel free to use the white trays located at the front desk. For patients who wear glasses, please remove them before lying face down.

□ ADJUSTING AND CHECKING AREAS

Out of respect for each and every one of our patients, you will be informed when it is your turn to be adjusted. You may then walk back to the adjusting room. Make sure the head rest paper has been changed and then lie face down on the table. The reason we request you to lie down is to relax your muscles prior to your adjustment. Please limit all conversations in these areas to your care.

□ YOUR APPOINTMENTS

The doctor will let you know when he/she needs to see you next. We set aside a time slot where we can be with you 100%. This is your time. If you must reschedule an appointment, please notify the office 24 hours prior to the change. All appointments must be made up as soon as possible in the week for which the change occurred. The appointment cannot be skipped because keeping to your schedule is a critical component in your care. We recognize that emergencies can arise. If you are unable to make it on time, please call to give notice. We will fit you in.

□ YOUR HEALTH

Spinal healing and correction takes time. If at any stage in your care you do not feel that you are responding as well as you expected, please discuss your concerns with our office immediately. We will schedule a special time for you with the doctor to discuss your concerns. We want you to get the most from your chiropractic care. Remember it is not how you are feeling, but it is how you are healing.

□ OFFICE HOURS

Monday, Wednesday, Friday are as follows: 8am-10:30am/3pm-6 PM
Any other appointments outside of our office hours are up to the doctor's discretion and by appointment only.

□ FINANCES

Payment is due at the time of service, unless other arrangements have been made prior to care. There will be a $25 service charge for all NSF checks. Any balances 60 days passed due without prior arrangements may be referred to collections and will be assessed a 35% service fee. I authorize Focused On You Chiropractic, its agents, representatives, and attorneys (including collection agencies) to contact you via current and future cellular phone number(s), email address, or wireless device(s) regarding my delinquent account. I authorize the use of automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls and e-mails, in efforts to contact me in purpose of collecting a portion of the past due account.

□ CHIROPRACTIC QUALITY

The doctors are periodically out of the office to attend seminars and conferences to further their education and the quality of chiropractic care they can bring to their patients. We will build your schedule around those times. Increasing visit frequency before and/or after the scheduling change will make up for patient and/or doctor absenteeism.

I have read and understand as well as agree to these policies.

Patient Signature _____Date _____

HIPPA Patient Consent Form

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. **Your Personal Health Information (PHI) will never be given to any entity besides what is required for your treatment, payment, and health care operations.**

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as radiologists that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Dr. Gerard Liboiron, D.C.

You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

I have read the HIPAA Patient Consent Form. All questions I have regarding this policy have been answered.

Patient Signature _____Date _____

Pregnancy Release: Informed Consent to X-ray

To be completed on day of x-ray, if x-rays are to be taken.

All women of childbearing age must sign this release and check the appropriate category.

"This is to certify that, to the best of my knowledge, I am not pregnant. The images radiology consultant and/or doctor has my permission to take x-rays. I will assume all responsibility for all effect on a fetus potentially present."

[ ] I am presently using birth control pill, contraceptive, or an IUD as a form of birth control

[ ] I have started my menstrual period in the last 10 days
Date: _____

[ ] I have had a hysterectomy or tubal ligation

[ ] I am presently in menopause or post-menopause

[ ] Other
Please Explain: _____

[ ] None of the above

Patient Name: _____

Signed: _____

Date: _____

Witness Name (if applicable): _____

Signed: _____