COLUMBIA CHIROPRACTIC CENTER

Keeping Columbia Moving.

Patient

Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

HIPPA CONSENT

Patient Name: _____ Date: _____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20_____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

PATIENT APPLICATION FOR ADMISSION

PATIENT INFORMATION

Legal Name_____ How would you like to be addressed?_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Email:_____ SSN#:____-____-_____ Date of Birth:____/____/_____ Age:_____
☐Male ☐Female Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced
If you have children, how many?_____ Names and Ages:_____
Emergency Contact:_____ Relationship:_____ Phone:_____
Preferred contact methods: ☐Cell phone ☐Home phone ☐Work Phone ☐Email ☐Text(cell carrier)_____
Employer _____ Occupation _____
How did you hear about our office?
☐Columbia Chiropractic Center Website ☐Search Engine:_____ ☐Community Event:_____
☐Health Talk:_____ ☐Law Firm:_____ ☐Dr Referral:_____
Patient Referral - who can we thank for sharing the benefits of care with you?_____
Have you ever had Chiropractic Care? ☐Yes ☐No
If yes, please tell us the doctor's name and when care occurred: _____
Were you pleased with your care? ☐Yes ☐No
Are you receiving care from other health care professionals? ☐Yes ☐No
If yes, please name them and their specialty: _____
Who is your family's primary care physician: _____ Location: _____
Columbia Chiropractic Center believes that health care is a team effort. May we have your permission to update your medical doctor regarding your care at this office? ☐Yes ☐No

Please list any medications, herbs, supplements, homeopathies or other remedies you are currently taking:

_____

_____

Please list any surgeries you've had and the date: _____

_____

_____

_____

INSURANCE

Have you provided our staff with a copy of your insurance card? ☐Yes ☐No
If no, please present your card upon completing this paperwork
How are you insured? (check all that apply)
☐Individual policy ☐Insured through employer ☐Medicaid (Title 19)
☐Medical Savings Account & Flex Plans ☐Automotive/Work Comp ☐Other: _____
If policy holder is someone other than the patient, please provide:
Policy Holder Name: _____ DOB: _____/_____/_____
Relationship: _____ SSN: _____-_____-_____
Address (if different from above): _____
Street City State Zip

NOTICE OF AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

FAMILY & SOCIAL

How often do you drink alcoholic beverages? _____ Do you smoke? ☐Yes ☐No How much? _____

Do you exercise? ☐Yes ☐No How often? _____ Type? _____

Women: Are you currently pregnant? ☐Yes ☐No Date of last menstrual cycle? _____

Check those involving family and include identification: **M** = mother, **F** = father, **S** = sibling, **G** = grandparent

Cancer, type_____	Depression	Diabetes	Back Problems
☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G
Heart Disease	Liver Disease High	Blood Pressure	High Cholesterol
☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G
Lung Problems	Scoliosis	Neck Problems	Osteoporosis
☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G
Seizures	Osteoarthritis	Rheumatoid Arthritis	
☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	☐M ☐F ☐S ☐G	

CHIROPRACTIC

Do you know what a subluxation is? ☐Yes ☐No

Do any of your friends or relatives see a chiropractor? ☐Yes ☐No

If yes, do they use chiropractic for: ☐Health maintenance/optimization ☐ Health problems ☐Both

Are you seeking chiropractic for: ☐Health maintenance/optimization ☐ Health problems ☐Both

Are you aware of the massive benefits of chiropractic care for children? ☐ Yes ☐ No

What would you like to gain from chiropractic care?_____

_____

_____

AUTHORIZATION

Consent for Treatment

Assignment & Release *- By signing below, I authorize Columbia Chiropractic Center to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Columbia Chiropractic Center and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my informed consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Name of Patient: _____Date: _____

Signature of Patient/Legal Guardian: _____

In the event that we can help, what is your level of commitment to correcting your problem (s)?

LOW MEDIUM HIGH

1	2	3	4	5	6	7	8	9	10

Present Health Condition

In order of importance, list the health problems you are most interested in getting corrected:

1. _____
2. _____
3. _____
4. _____

List approximately how long you have noticed these problems:

1. _____
2. _____
3. _____
4. _____

Is there a certain time of day any of these problems are better or worse?

_____
_____
_____
_____

List the things you have used for these problems:

Gabapentin Neurontin Lyrica Cymbalta
Physical Therapy Pain Medications Aleve
Tylenol Ibuprofen Motrin Chiropractic
Massage Therapy Injections Creams

Is your balance/walking ability affected?
If yes, please describe:

_____
_____
_____
_____

What do you think is causing your problem?

_____
_____
_____
_____

Name of all doctors you have seen for these problems and treatment you received:

_____

Neuropathy Consult

Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

List anything that makes your condition worse _____

_____

List anything that makes your condition better _____

_____

How would you describe the symptoms? Please check ALL that apply

☐ Aching Pain	☐ Numbness	☐ Hot Sensation	☐ Cramping
☐ Stabbing Pain	☐ Tingling	☐ Throbbing Pain	☐ Swelling
☐ Sharp Pain	☐ Pins & Needles Pain	☐ Dead Feeling	☐ Burning
☐ Tiredness	☐ Heavy Feeling	☐ Cold Hands/Feet	☐ Electric Shocks

Is this condition interfering with any of the following?

☐ Sleep	☐ Work	☐ Daily Activities
☐ Recreational Activities	☐ Walking	☐ Standing

Current Pain Level

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

QUALITY OF LIFE

Please take several minutes to answer these questions so we can help you get better.

(Please circle as many that apply)

1. How have you taken care of your health in the past?

a. Medications
b. Emergency Room
c. Routine Medical
d. Exercise e. Nutrition/Diet
f. Holistic Care
g. Vitamins
h. Chiropractic
i. Other (please specify): _____

2. How did the previous method(s) work out for you?

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

3. How have others been affected by your health condition?

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self-esteem
f. Sleep
g. Time
h. Finances
i. Freedom

5. Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

➡ **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

_____

➡ **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:**

1. _____ 2. _____ 3. _____

➡ **What are you most concerned with regarding your problem?**

_____

➡ **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific**

_____

➡ **What would be different/better without this problem? Please be specific**

_____

➡ **What do you desire most to get from working with us?**

_____

➡ **What would that mean to you?**

_____

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Pregnancy Waiver

I hereby acknowledge that a doctor from Columbia Chiropractic Center has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated of my own volition that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____

Printed name of patient

_____

Date

_____

Signature of Patient/ Authorized Representative of Patient

WITNESSES

_____

Printed name

_____

Signature