

**New Patient Information and History**

Date: \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home phone: \_\_\_\_\_ work phone: \_\_\_\_\_ cell phone: \_\_\_\_\_

Email address: \_\_\_\_\_

**Employment Information:**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

SSN# \_\_\_\_\_ TXDL: \_\_\_\_\_

Person responsible for payment: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy # \_\_\_\_\_

**Medical Information:**

Who is your primary care physician? \_\_\_\_\_

May we share information with your primary care physician?    Yes    No

Have you even been to a chiropractor before? \_\_\_\_\_

If yes, what were you treated for & when? \_\_\_\_\_

Have you been treated for other health conditions within the past year? \_\_\_\_\_

What is your primary reason for coming in today? \_\_\_\_\_

When did your problem begin? \_\_\_\_\_

Have you been treated for this condition in the past? \_\_\_\_\_

If yes, who was your provider? \_\_\_\_\_

If yes, what was your previous treatment? \_\_\_\_\_

Is there anything that makes this condition better? \_\_\_\_\_

Is there anything that makes this condition worse? \_\_\_\_\_

Can you describe how your pain feels? \_\_\_\_\_

On a scale of 1-10, how would you rate your pain? (1 = no pain to 10 = unbearable pain?) \_\_\_\_\_

Describe where your primary pain is? \_\_\_\_\_

Do you have pain anywhere else? \_\_\_\_\_ If yes, where? \_\_\_\_\_

Is there any activities that make your pain worse, if so what? \_\_\_\_\_

Is there a time of day when it is worse? \_\_\_\_\_

Do you have any food or drug allergies, if so, please explain? \_\_\_\_\_

What medications are you taking? \_\_\_\_\_

Do you take vitamins? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_\_ If yes, when and for what? \_\_\_\_\_

Have you had any others injuries? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Are you married: \_\_\_\_\_ Do you have children? \_\_\_\_\_ Do you smoke, if yes, how much? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_

Do you exercise and if yes, how often? \_\_\_\_\_

Do you eat healthy? \_\_\_\_\_

Do you consider your job stressful? \_\_\_\_\_

**Please read the following and circle any that you have or have had?**

Appendicitis	Aids/HIV	Alcoholism	Allergy Shots	Anemia
Anorexia	Arthritis	Asthma	Bleeding Disorders	Breast Lump
Bronchitis	Bulimia	Cancer	Cataracts	Chemical Dependency
Chicken Pox	Diabetes	Emphysema	Epilepsy	Fractures
Glaucoma	Goiter	Gonorrhea	Gout	Heart disease
Hepatitis	Hernia	Herniated disk	Herpes	High cholesterol
Kidney disease	Liver disease	Measles	Migraines	Miscarriage
Mononucleosis	Multiple sclerosis	Mumps	Osteoporosis	Pacemaker
Parkinson's disease	Pinched nerve	Pneumonia	Polio	Prostrate problem
Prosthesis	Psychiatric care	Rheumatoid arthritis	Rheumatic fever	Scarlet fever
Stroke	Suicide attempt	Thyroid problems	Tonsillitis	Tuberculosis
Tumors/growths	Typhoid fever	Vaginal infections	Venereal disease	Whooping cough

If anything is circled, please explain:

Women: when was your last menstrual cycle? \_\_\_\_\_

Men: when was your last prostate exam? \_\_\_\_\_

What did you have for your last meal? \_\_\_\_\_

**Please read the following carefully:**

**I have answered the information to the best of my ability. I have not purposely omitted false information about myself. If I become aware of new information, I will notify the doctor or staff immediately. I understand that even though this office verifies my insurance benefits, it is not a guaranty of payment by my insurance provider. In the event that my insurance does not pay for services rendered, I will be responsible for payment. Unless I have made prior arrangements, payment is due at time of service. I authorize release of any medical or other information to process claims. I authorize payment of medical benefits to the undersigned physical or supplier for services rendered.**

Patient Signature or Authorized Person: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I have received information regarding patient privacy.

Patient Signature or Authorized Person: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## **Understanding Your Health Record/Information**

For the purposes outlined in this Notice, the term "you" and references to you means you and the person with legal authority to make health care decisions on your behalf. If you are an unemancipated minor, this means your parent, guardian or other person acting in place of your parent. If you are an emancipated minor, this means the person with legal authority to make healthcare decisions on your behalf.

For each day of treatment you receive at Wellness & Better Health Chiropractic, P.A., a record is made. Typically, this record includes a description of your diagnoses, the results of any tests or assessments that you were given, the interventions used to help you improve, and the progress you make toward achieving the goals on your treatment plan. This information, often referred to as your client or medical record, serves as a:

- basis for planning your care and treatment;
- means of communication among the many health care professionals who contribute to your care;
- legal document describing the care you received;
- means by which you or a third party payer can verify that services billed were actually provided;
- a tool in education of health care professionals;
- a source of data for facility planning and marketing;
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy;
- better understand who, what, when, where, and why others may access your health information;
- make more informed decisions when authorizing disclosure to others.

### **Your Health Information Rights**

Although your record is the physical property of Wellness & Better Health Chiropractic, P.A., the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by the regulations supporting the Health Insurance Portability and Accountability Act (HIPAA);
- obtain a paper copy of this notice of information practices;
- inspect and obtain a copy of your record as provided for in HIPAA and The Centers' Privacy Plan;
- amend your health record as provided in HIPAA;
- obtain an accounting of disclosures of your health information as provided in HIPAA;
- request confidential communications of your health information by alternative means or at alternative locations;
- revoke your authorization to use or disclose health information except to the extent that action has already been taken;
- receive a copy of this notice in a language you can understand and to have it explained to you by a staff member.