**DEAN WELLNESS CENTER**

# PATIENT INFORMATION

Case #

***WELCOME! Please allow our staff to photocopy your driver's license and all available insurance cards.***

**PLEASE PRINT.**

Full Name _____ Email: _____ Gender: **M F** Age Birth Date / /

Address _____ City _____ State _____ Zip _____

Marital Status (Circle One): **S M W D Sep** No. Children _____ **Home Phone** (_____)_____

SS#_____ Driver's License # _____ **Cell Phone** (_____)_____

Your Employer _____ Your Occupation_____ **Work Phone** (_____)_____

Employer Address _____ City_____ State _____ Zip_____

Do you have health insurance where you work? _ Yes _NO Plan/Group # _____

Insurance Company _____

Name of Spouse, Parent or Guardian _____ Age _____ Birth Date _____ SSN# _____

Spouse's Employer _____ Spouse's Occupation_____ Work Phone (_____)_____

In case of an Emergency Contact:_____ Relationship:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

**How did you find out about our office, or whom may we thank for referring you?** _____

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 operations 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 HIPAA 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, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to 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 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.**

**Patient's Signature** _____ **Date** _____

**Spouse's or Guardian's Signature**_____ **Date** _____

**PLEASE TURN FORM OVER AND CONTINUE**

## Complaint/Problem

What is your current health problem or complaint? _____

When did you first seek treatment for this problem? ___/___/____ Have you seen other doctors for this condition? Y ☐ N ☐

How many days within the past year have you suffered with this condition? _____ How long has this episode lasted? _____

Is your condition accident related? Y ☐ N ☐ If so, was the accident related to: Work ☐ Auto ☐ Other _____

Date of accident: ___/___/____ Time of accident: ___:____am / pm Location: _____

Do you have an attorney advising you? Y ☐ N ☐ If so, which attorney/firm: _____

Please rate the pain relating to your current condition using the following scale: (0= No Pain thru 10= Worst Pain)

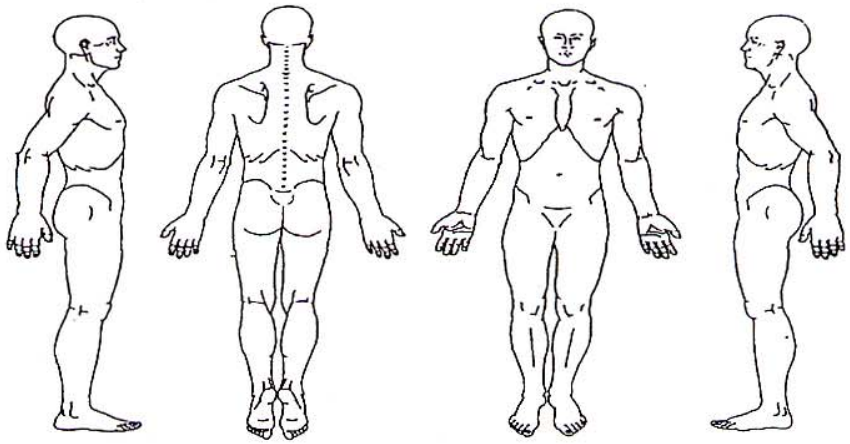
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Current pain intensity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Average pain intensity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Worst pain intensity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Please check the symptoms you have experienced since your accident or the onset of your condition:

- ☐ Low back pain
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Sore Muscles
- ☐ Tingling in hands
- ☐ Excessive thirst
- ☐ Urination difficulty
- ☐ Muscle aches
- ☐ Constipation
- ☐ Forgetfulness
- ☐ Irritability
- ☐ Ankle pain
- ☐ Foot pain
- ☐ Facial pain
- ☐ Tingling in feet
- ☐ Upset stomach
- ☐ Poor Circulation
- ☐ Shakiness
- ☐ Headache
- ☐ Lump in throat
- ☐ Menstrual irregularities
- ☐ Elbow or hand pain
- ☐ Clammy hands
- ☐ Blurred vision
- ☐ Sweating
- ☐ Swallowing pain
- ☐ Insomnia
- ☐ Unsteady voice
- ☐ Fainting
- ☐ Choking
- ☐ Convulsions
- ☐ Confusion
- ☐ Earache
- ☐ Slow heart rate
- ☐ Rapid heart rate
- ☐ High blood pressure
- ☐ Impatience
- ☐ Burning or unpleasant taste
- ☐ Dizziness
- ☐ Frequent urination
- ☐ Abdominal pains
- ☐ Teeth grinding
- ☐ Stomach burning
- ☐ Feel loss of control
- ☐ Hay fever
- ☐ Sinusitis
- ☐ Low blood pressure
- ☐ Dry mouth
- ☐ Walking problems
- ☐ Nausea
- ☐ Vomiting
- ☐ Fullness of bladder
- ☐ Hemorrhoids
- ☐ Decreased sex drive
- ☐ Persistent coughing
- ☐ Swollen Joints
- ☐ Poor appetite
- ☐ Sore throat
- ☐ Weak Muscles
- ☐ Paralysis
- ☐ Swollen ankles
- ☐ Chest pressure
- ☐ Joint stiffness
- ☐ Eye pain
- ☐ Fatigue
- ☐ Knee pain

Please use the legend symbols below to accurately mark the areas in which you feel the above described sensations:

Stabbing/Cutting - ||| Burning - XXX Numbness - === Tingling (Pins & Needles) - :::: Cramping - ^^^ Dull - ###



## History

Have you ever been treated by a chiropractor before? Y ☐ N ☐ Age when you first experienced spinal problems: _____ yrs

| Have you ever suffered from: | | | | |
|---|---|---|---|---|
| Backache | Y ☐ N ☐ | Asthma: | Y ☐ N ☐ |
| Heart Trouble: | Y ☐ N ☐ | Pinched Nerve: | Y ☐ N ☐ |
| Tuberculosis: | Y ☐ N ☐ | Sinus Problems: | Y ☐ N ☐ |
| Headache: | Y ☐ N ☐ | Anemia: | Y ☐ N ☐ |
| Dizziness: | Y ☐ N ☐ | Chest Pain: | Y ☐ N ☐ |

Do you smoke?: Y ☐ N ☐ If so, how many packs per day? < 1 ☐ 1 ☐ 2 ☐ 3 ☐ 3+ ☐

Do you drink?: Y ☐ N ☐ If so, how much? Light ☐ Moderate ☐ Heavy ☐

Have you had x-rays taken of the following: Back ☐ Neck ☐ Chest ☐ Other ☐ Last X-Ray Date: ____/____/_____

Have you been treated for any other health condition in the past year? Y ☐ N ☐

If so, please identify: _____

## Disability Questionnaire

The rating scales used below measures the impact of your pain on your everyday life. The doctor wants to know how much your current condition is preventing you from doing your normal activities. For each of the seven (7) categories listed below, circle the one number between "0" and "10" that best indicates the level of interference that you are experiencing in your normal activities. If a category does not apply to you, circle "0". A score of ten "10" indicates that all of the activities that you would normally do have been disrupted by your pain or condition. Your rating should be a reflection of the overall impact of your condition on your life, not just the amount of interference when your condition is at its worst.

**Family and/or Home:** This category refers to those activities related to your home and family responsibilities.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| No Disability | | Mild | | Moderate | | Severe | | Total Disability | |

**Recreation:** Indicate how much your existing condition interferes with your recreational activities.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| No Disability | | Mild | | Moderate | | Severe | | Total Disability | |

**Social:** Indicate the overall level of disability on your social activites caused by your condition.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| No Disability | | Mild | | Moderate | | Severe | | Total Disability | |

**Occupation:** Indicate the amount of job-related interference you experience due to your present problem.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| No Disability | | Mild | | Moderate | | Severe | | Total Disability | |

**Interpersonal:** Indicate the level to which your condition interferes with the quality of your interpersonal relationships.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| No Disability | | Mild | | Moderate | | Severe | | Total Disability | |

**Self Care:** Indicate the amount of interference you experience with personal maintenance and independent living activites

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| No Disability | | Mild | | Moderate | | Severe | | Total Disability | |

**Sleeping:** Indicate the level of interference with sleeping caused by your condition.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| No Disability | | Mild | | Moderate | | Severe | | Total Disability | |

| Please answer the following questions: | Yes | No |
|---|---|---|
| Have you felt keyed up, on edge? | ☐ | ☐ |
| Have you been worrying a lot? | ☐ | ☐ |
| Have you been irritable? | ☐ | ☐ |
| Have you had a difficult time relaxing? | ☐ | ☐ |
| Have you been sleeping poorly? | ☐ | ☐ |
| Have you had difficulty falling asleep? | ☐ | ☐ |
| Have you been waking up early? | ☐ | ☐ |
| Have you tended to feel worse in the morning? | ☐ | ☐ |
| Have you had headaches or neckaches? | ☐ | ☐ |
| Have you had any tingling, dizzy spells, sweating, urinary infrequency, or diarrhea? | ☐ | ☐ |
| Have you been worried about your health? | ☐ | ☐ |
| Have you had low energy? | ☐ | ☐ |

| Please answer the following questions: | Yes | No |
|---|---|---|
| Do you get pain at the tip of your tailbone? | ☐ | ☐ |
| Does your whole arm or leg feel painful? | ☐ | ☐ |
| Does you whole arm or leg feel numb? | ☐ | ☐ |
| Have you had any pain-free times in the past year? | ☐ | ☐ |
| Have you had any intolerance to treatments or reactions to treatments? | ☐ | ☐ |
| Have you ever been to the emergency room For back pain? | ☐ | ☐ |

Under penalty of perjury, I attest that my answers to the above questions are complete and true.

X _____

***Patient Signature***