CONFIDENTIAL PATIENT INFORMATION

PERSONAL INFORMATION:

NAME: _____ TODAY'S DATE: _____

HOW DID YOU HERE ABOUT US?
____ NEWSPAPER ___FRIEND ____RADIO___ BUS STOP BENCH AD
____MEDICAL DOCTOR REFERRAL ___ ATTORNEY REFERRAL ___OTHER_____

ADDRESS: _____ APT #:_____

CITY: _____ STATE:_____ ZIP:_____

HOME PHONE: _____ **CELL PHONE**:_____ ETHNICITY:_____

BIRTH DATE: _____ **SOCIAL SECURITY NUMBER**: _____

SEX: ___ Male ___Female MARITAL STATUS: ___Single ___Married ___Divorced

STUDENT STATUS: ___N/A ___ F/T ___ P/T **E-Mail Address**: _____

EMPLOYER'S NAME: _____ **OCCUPATION**:_____

EMPLOYER CITY: _____STATE:_____ ZIP: _____

EMPLOYER ADDRESS: _____WORK PHONE: _____

SPOUSE'S\SIGNIFICANT OTHER'S NAME: _____

SPOUSE'S WORK PHONE: _____

EMERGENCY CONTACT INFOMATION:

FULL NAME: _____ PHONE NUMBER:_____

PRIMARY BANKING INSTITUTION NAME: _____

PLEASE CIRCLE ANY AND ALL INSURANCE COVERAGE THAT MAY BE APPLICABLE IN THIS CASE.

Major Medical Worker's Compensation Medicaid Medicare Auto Accident
Affordable Healthcare Act (Obama Care) Caresourse Health Savings Account

NAME OF PRIMARY INSURANCE COMPANY_____

NAME OF SECONDARY INSURANCE COMPANY (if any) _____

AUTO ACCIDENT PATIENTS ONLY:

ACCIDENT REPORTED: ___ No ___Yes ___Worker's Comp ___Insurance Carrier ___Employer

HAVE YOU RETAINED AN ATTORNEY FOR THIS ACCIDENT: ___Yes ___ No

IF YES, ATTORNEY'S NAME AND PHONE NUMBER: _____

NAME OF INSURANCE COMPANY OF THE AT FAULT PERSON: _____

NAME OF YOUR AUTOMOBILE INSURANCE: _____

NAME OF HEALTH INSURANCE: _____

History of Current Condition:

Describe Major Complaint:_____

Began When? ___/___/___ Describe how this began:_____
_____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

How frequent is the complaint present? Off & On / Constant

Does anything make the complaint better? _____

Does anything make the complaint worse?_____

Which daily activities are being affected by this condition? (*Describe*)_____

For this CURRENT condition, have you:

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other:_____**Where?**_____
- **Had any previous Surgery or Interventions in this area?**(*Describe*)_____
- **Taken any Medications?** OTC / Prescriptions _____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other:_____ **When and Where?**_____

Describe any Secondary Complaints:_____
_____

Health History-(Please use the reverse side of this page if additional space is needed)

Medications: **NONE** (List)_____
_____

Current Medications: **NONE**
*(Over the counter or Prescription)*_____
_____
_____

Past Health History: *(Please list any past...)*
Surgeries- Date, Type, and Reason: NONE
_____
_____
_____

Major Injuries/Traumas: NONE _____
_____
_____

Major Hospitalizations: NONE _____
_____
_____

Family Health History: *(Please mark N/A if not relevant)*
List relevant major health problems of immediate relatives:
_____
_____
_____

Death in immediate family: *(Cause and at what age?)*
_____

Prenatal History: Home / Birthing Center / Hospital
Birth Weight:_____ **Birth Length:** _____
Interventions: NONE / Forceps / Vacuum / C-Section
Complications: NONE /_____
Medications during pregnancy: NONE
_____

Feeding and Development History:
Breast fed: NO ☐ YES- How long?_____
Formula: ☐NO ☐ YES - What Type?_____
Food allergies or intolerance?: ☐NO ☐ YES
*If yes, please describe:*_____
_____

Rolling over: ☐NO ☐ YES **Sitting:** ☐ NO ☐ YES
Crawling: ☐ NO ☐ YES **Walking:** ☐ NO ☐ YES
Sleep: Hours/night_____ Sleep Well: ☐NO ☐ YES
Childhood Diseases: ☐NONE ☐ Chicken Pox ☐ Measles
☐ Meningitis ☐ Mumps ☐ Whooping Cough
☐ Rubella Other: _____
Has child been vaccinated?: ☐ **NO** ☐ **YES**
Any adverse reactions? : ☐ NO ☐ YES

Social and Occupational History:
Level of Education Completed:_____
Lifestyle: *(Hobbies, Rec, Activities, Exercise, Diet Work, Vitamins)*_____
_____
_____
_____

Review of Symptoms:

Are you *currently* experiencing any of these symptoms? (Check all that apply)
Many of the following conditions respond to Chiropractic treatment

General: (*constitutional*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems_____
- ☐ Leg Problems_____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscles Spasms/Cramps
- ☐ Broken Bones_____
- ☐ Other:_____
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Have you ever had a head injury?
- ☐ Ever been in an auto accident?
- ☐ Other:_____
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other:_____
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/Strain w Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other:_____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movement
- ☐ Painful Bowel Movement
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other:_____
- *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat Changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other:_____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other:_____
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear Contacts/Glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other:_____
- ☐ *None in this Category*

Ears, Nose, and Throat:
- ☐ Bleeding gums/mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen Throat or Voice Change
- ☐ Swollen glands in the neck
- ☐ Ringing in the ears
- ☐ Ear-Ache/Ringing/Drainage
- ☐ Sinus/Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other:_____
- ☐ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in Hat or Glove size
- ☐ Dry Skin
- ☐ Glandular or Hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other:_____
- ☐ *None in this Category*

Skin and Breast:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in Hair or Nails
- ☐ Non-Healing sores
- ☐ Change of Appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other:_____
- ☐ *None in this Category*

Women Only:
Are you pregnant? Y or N
If so, Due Date_____
If not, Last menstrual period_____
- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other:_____
- ☐ *None in this Category*

Pregnancies with Outcome & Date:
_____
_____
_____
_____

Comments:_____
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with Chiropractic Care, Diagnostic testing, and/or therapeutic Services, in accordance with the state's statutes.

Patient or Guardian Signature_____Date_____

TERMS OF ACCEPTANCE:

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, consent to treatment, assign benefits, authorization and release, and agree to our office policies. If you refuse to sign this consent the chiropractic physician has the right to refuse care.

NOTICE OF PRIVACY PRACTICES: (HIPPA) I understand and acknowledge the "Notice of Privacy Practices", effective 9/23/2013, and agree to its terms and conditions. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

ELECTRONIC HEALTH RECORDS: I understand that a Clinical Summery Report (CCR) is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Owens Chiropractic and Rehabilitation Center, LLC to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

INFORMED CONSENT: A patient, in coming to Owens Chiropractic and Rehabilitation Center, LLC (OCRC), gives Dr. Stephanie Owens (the doctor) permission and authority to care for the patient in accordance with the chiropractic test, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or learn otherwise not to come to the attention of Dr Owens. The doctor provides a specialized, non-duplicating health care service. I understand that if I am accepted as a patient at OCRC, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request. I understand that I have the right to refuse services at any time, and will be informed of any changes in treatment prior to their performance. By signing this form, and once treatment is accepted, informed consent has been satisfied. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office. The patient may provide a written request to revoke consent at any time during care.

ASSIGNMENT OF BENEFITS: I understand that i am fully responsible for the payment of services rendered. i further understand that health and accident insurance policies are an arrangement between me and the carrier, and that I may be required to pay some or all of the fees charged to my account. I hereby assign benefits to be paid directly to this provider by my third - party payer (i.e. insurance company, attorney, etc.) My signature below show agreement that is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between me and Dr. Stephanie Owens dba Owens Chiropractic and Rehabilitation Center, LLC.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Dr. Stephanie Owens (the doctor) dba Owens Chiropractic and Rehabilitation Center, LLC. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers 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. I understand that interest is charged on overdue accounts at the annual rate of 16% plus any postage fees that applies.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date:_____

Guardian's Signature Authorizing Care _____ Date:_____

I ATTEST THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT: _____ DATE:_____