

New Patient Health History Form

In order to provide you the best possible care, please complete this form.
All information is strictly CONFIDENTIAL.

Patient Data

First Name _____ Last Name _____ Date _____

Email* _____

Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Mailing Address

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Cell) _____ (Work) _____

Age _____ Birth Date _____ Social Security # _____

Number of Children _____ Height _____ Weight _____ Marital Status: M S W D

Occupation _____ Employer _____

Spouse's Name _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Health Status _____

Emergency Contact Phone _____

Referred By _____ Have you visited our website? No Yes

Current Complaints

Nature of Injury: Automobile* Work Other

Please describe: _____

Date of Injury _____ Date symptoms appeared _____

Have you ever had same condition? No Yes If yes, when? _____

List of other practitioners seen for this injury/condition _____

Have you ever been under chiropractic care? No Yes If yes, please describe _____

Payment Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? No Yes Name of company _____

*** If an auto accident, please provide:**

Your Auto Insurance Company Name _____ Contact Person _____

Phone: _____ Claim # _____

Signatures

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If Yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc) _____

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency). _____

Have you ever:	No	Yes	Briefly Explain
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Broken bones?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Been hospitalized?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Been in an auto accident?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Had Sprains/Strains?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Been struck unconscious?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Had surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.) _____

Do you experience pain every day? No Yes

Do your symptoms interfere with daily life? No Yes

Does pain wake you up at night? No Yes

Are your symptoms worse during certain times of the day? No Yes

Do changes in weather affect your symptoms? No Yes

Do you wear orthotics? No Yes

Do you take vitamin supplements? No Yes

What activities aggravate your symptoms? _____

Habits	None	Light	Moderate	Heavy
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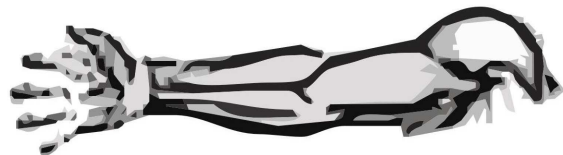
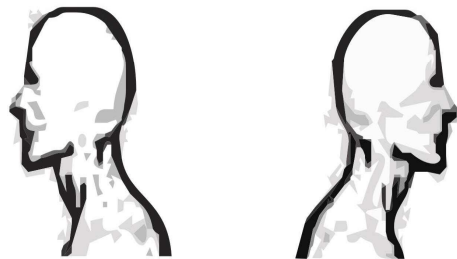
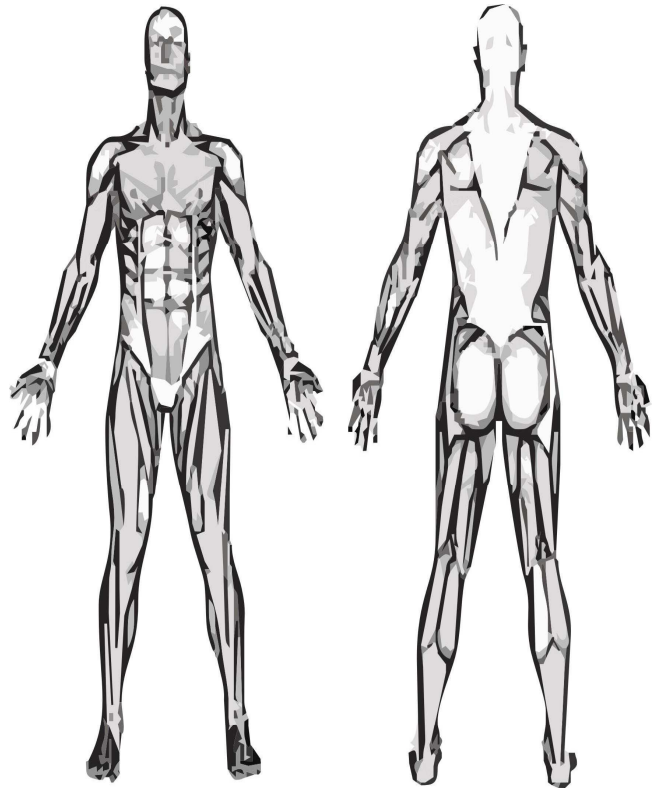
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

- A**=Ache
- B**=Burning
- N**=Numbness
- O**=Other
- P**=Pins & Needles
- S**=Stabbing



Appendix B

Acknowledgement of Privacy Notice

As of April 14, 2003, our office is implementing the requirements of the Health Insurance Portability, and Accountability Act (HIPAA), which was passed by the federal legislature.

Your signature is necessary so that we may continue to treat you and submit your information for reimbursement.

Please review the 'Privacy Notice' and indicate that you have reviewed this document by signing below.

“My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider’s Notice Of Privacy Practice.

Print Name

Date

Signature

Ellison Family Chiropractic Terms of Acceptance

Chiropractic:

Chiropractic seeks to restore health through natural means without the use of medicine or surgery. This gives the body the maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic depends on the environment, underlying irritants, physical and spinal problems.

Analysis:

Ellison Family Chiropractic conducts a thorough chiropractic evaluation and utilizes the most recent research evidence and technology to develop a solution for each patient.

Diagnosis:

Dr. Ellison will when necessary refer you to other physicians for consultation and/or additional work up. While Dr. Ellison is an expert in spinal subluxations (misalignments) and misalignments throughout your body, each patient should secure on their own other opinions if the patient has additional concerns about their health.

Informed Consent:

Ellison Family Chiropractic utilizes Activator Methods Chiropractic Technique to adjust patients' spinal subluxations and other misalignments throughout the body. Ellison Family Chiropractic adjusts patients in an open setting to minimize patient wait time, to keep staff involved in patient care and to allow for easier discussion of chiropractic tenets. If the patient is uncomfortable with this style of adjusting please inform the front desk upon arriving and you will be provided with a private room. If you have a question for Dr. Ellison and you would like more privacy, let the doctor or staff know and time will be available to discuss your question.

Results:

The purpose of chiropractic is to promote health through the reduction of subluxations or misalignments using Activator Methods Chiropractic Technique. Since there are so many different variables, it is difficult to predict outcomes. Sometimes response is phenomenal. In most cases response is gradual but satisfactory. And occasionally response is less than expected. Two or more similar conditions often respond differently to chiropractic adjustments.

To The Patient:

Please discuss any questions or concerns with Dr. Ellison or a staff member before signing this policy.

I have read and understand the foregoing.

Signature

Date

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at Ellison Family Chiropractic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed)

Relationship to patient

Patient or legal Guardian Signature

Date

Witness Signature (office staff)

Date

ELLISON FAMILY CHIROPRACTIC
1560 N. CRESTMONT DR. STE. G
MERIDIAN, ID 83642
(208) 884-8848

DATE _____

PATIENT _____ DOB _____

EMPLOYER _____

ID#/SS# _____ GROUP _____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to Ellison Family Chiropractic, or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it to the address above for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of policy holder

Signature of claimant, if other than policy holder

Witness