Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date:_____ Patient #_____ **Doctor:** Dr Marcus Deaver, D.C.

Name:_____ Social Security #_____ Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Fax #_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____ Names and Ages of Children:_____

_____

Emergency contact name:_____ Address:_____ Phone:_____

Family Medical Doctor:_____

May we have your permission to contact your medical doctor regarding your care at this office?_____

Previous Chiropractic Care? ( ) Yes ( ) No Chiropractor's Name_____

When was your last visit?_____ What was the reason for your initial visit?_____

What spinal maintenance programs were you given to follow to maximize the future of your spine?

_____

Did you follow it? ( ) Yes ( ) No - If not, why?_____

Who referred you to our Office? _____

How would you want us to handle your problem!

( ) **Temporary relief**

( ) **Maximum correction**

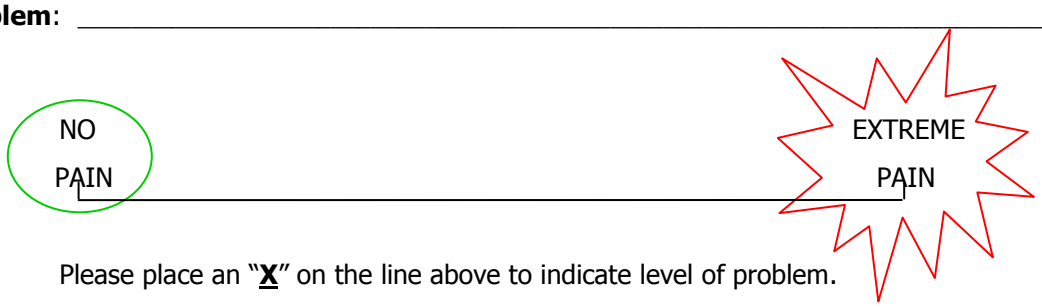
( ) **Are you interested in Wellness?**

What are your expectations of us? _____

What is your health Philosophy? _____

HISTORY OF PRESENT ILLNESS:

Main Problem: _____



Please place an "**X**" on the line above to indicate level of problem.

Frequency (in 1 day) **:** ( ) Intermittent **< 25**% ( ) Occasional **25%-50%**

( )Frequent **50%-75%** ( ) Constant **>75**%

Date symptoms appeared or accident happened:_____

Is this due to: ( ) Auto ( ) Work ( ) Other_____

What makes the problem **Better**? _____

What makes the problem **Worse**? _____

Describe the **Quality of Pain**: ( ) Aching ( ) Dull ( ) Sharp ( ) Stabbing

( ) Electric ( ) Fiery ( ) Shooting Other _____

Does the pain **radiate** to any part of your body? ( ) Yes ( ) No _____ If yes, describe._____

Timing : ( ) Morning ( ) Afternoon ( ) Evening ( ) During Night

Has it become **worse** recently? ( ) Yes ( ) No

If yes, when and how? _____

Have you seen any **other professional** for this condition?_____

What does this **prevent** you from **doing** or **enjoying**? _____

_____

MEDICATIONS List medications you are currently taking	VITAMINS/HERBS/MINERALS
_____ _____ Medical Allergies_____ _____	_____ _____ _____ _____ _____

Have you had any **major illnesses?** (Describe) _____

Have you had any **surgeries?** (Describe) _____

Have you had any **auto accidents**? (Describe)_____

Have you been treated for **any** health condition by a **physician** in the **last year**? ( ) Yes ( ) No

- If yes, describe:_____

GENERAL SYMPTOMS

Check the symptoms you **currently** have.

( ) Bruise easily	( ) Migraines	( ) High Cholesterol	( ) Hemorrhoids
( ) Sweats	( ) Headaches	( ) Pace Maker	( ) Kidney Disease
( ) Poor Circulation	( ) Crossed Eyes	( ) Liver Disease	( ) Forgetfulness
( ) Hives	( ) Ear Discharge	( ) Stomach Pain	( ) High Blood Pressure
( ) Chills	( ) Nosebleeds	( ) Indigestion	( ) Swelling in ankles
( ) Fever	( ) Vision - Flashing	( ) Bloating	( ) AIDS/HIV
( ) Rash	( ) Vision - Halos	( ) Excessive hunger	( ) Arthritis
( ) Change in Moles	( ) Stroke	( ) Excessive thirst	( ) Asthma
( ) Varicose Veins	( ) Thyroid Problems	( ) Vomiting / Nausea	( ) Cancer
( ) Dizziness	( ) Irregular heart beat	( ) Difficulty Swallowing	( ) Depression
( ) Double Vision	( ) Chest Pain	( ) Ulcers	( ) Osteoporosis
( ) Ringing in Ears	( ) Persistent Cough	( ) Gas	( ) Diabetes
( ) Blurred Vision	( ) Coughing Blood	( ) Constipation	( ) Difficulty Sleeping
( ) Earache	( ) Gall Bladder	( ) Rectal Bleeding	( ) Tired all day long
( ) Loss of Hearing	( ) Breast Lump	( ) Bladder control	( ) Allergies (Seasonal)
( ) Sinus problems	( ) Heart Disease	( ) Diarrhea	( ) Broken Bones

MEN only

( ) Breast lump	( ) Erection difficulties	( ) Lump in testicles	( ) Prostate Problems
( ) Sore on penis	( ) Frequent Urination	( ) Painful Urination	( ) Other _____

WOMEN only

( ) Abnormal pap smear	( ) Breast lump	( ) Hot flashes	( ) Bleeding between periods
( ) Extreme menstrual pain	( ) Nipple discharge	( ) Painful intercourse	( ) Vaginal discharge
( ) Miscarriage	( ) Vaginal Infection	( ) Painful Urination	( ) Other_____

Date of last menstrual period_____ **Is there a chance you might be pregnant**? ( ) Yes ( ) No

SOCIAL HISTORY

( ) Smoking
( ) Other Tobacco
( ) Alcohol Use
( ) Coffee
( ) Tea
( ) Pop

Diet is
( ) Balanced
( ) Unbalanced

Rest is
( ) Sufficient
( ) Not sufficient

Family Stress is
( ) Severe
( ) Moderate
( ) Minimal

My Job Stress is
( ) Severe
( )Moderate
( ) Minimal

Do you **exercise**? ( ) Yes ( ) No - If yes, what is the frequency and type of exercise?_____

What are your **hobbies**? _____

Patient Health Information Consent Form

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, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the 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 Signature: _____ **Date**: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments 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 health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Art of Life Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ **Date**: _____