HEALTH INFORMATION AND HEALTH HISTORY

Patient Name: ____ Gender: __ Male __ Female

Marital Status: __ Married __ Single __ Divorced __ Widowed __Other ______________________

Date of Birth: ______-______-______ Patient Social Security Number: ______-______-______

Spouse Name: ____________________________ Number of Children: _____________________

Patient Address: __________________________ City: ______________________ Zip: _________

Phone (Home):_______-_______-_______ Cell Number: _______-_______-_______

E-mail Address: ___________________________ Employer: _______________________________

Occupation: ___________________________ Referred By: ________________________________

Name and Phone Number of emergency contact or nearest relative not living with you:
____

Is this condition due to: __Work Related Accident __ Auto Accident __Personal Injury

Do you have Health Insurance? __ Yes __ No

Name of Insurance Company: _________________________________ ID# ___________________

Is your spouse employed? __ Yes __ No

Is your spouse the primary insured? __ Yes __ No If yes, please give Date of Birth: ____-____-____

Are you covered by Medicare? __ Yes __ No

I authorize **BACK, BODY & BEYOND CHIROPRACTIC** to release medical information to my insurance company:

Signature: ____________________________________ Date: _________________________________

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment if my insurance carrier does not pay. I also understand that payment of services is due at the time of service unless other financial arrangements have been made.

HEALTH INFORMATION AND HEALTH HISTORY

COMPLAINTS

Primary Complaint? ____

Secondary Complaint? ____

When did your problem begin? ____

How did your problem begin? ____

Is this problem interfering with your: (Please circle all that apply)

Activities of daily living   Work   Social Activities   Hobbies   Sleep

RATE YOUR PAIN: SEVERITY OF PAIN

a) List the areas of pain **and** b) Circle the number below to describe the amount of pain.
"1" indicating minor discomfort and "10" representing severe pain.

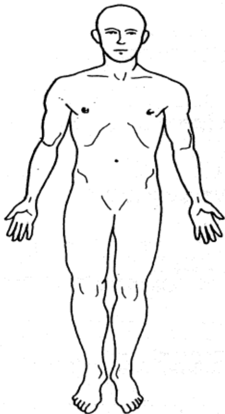
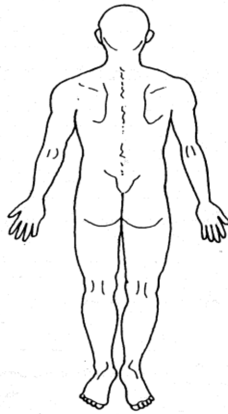
1. __________________________ 1 2 3 4 5 6 7 8 9 10

2. __________________________ 1 2 3 4 5 6 7 8 9 10

3. __________________________ 1 2 3 4 5 6 7 8 9 10

4. __________________________ 1 2 3 4 5 6 7 8 9 10

Please mark areas of pain on the drawings using the code listed.
burning (+++)   stabbing (000)   sharp (---)   aching (///)

Please list any concerns about your symptoms and anything else you would like the doctor to know: ____

HEALTH INFORMATION AND HEALTH HISTORY

COMPLAINTS

Is your health problem worse: Morning Day Evening Night

Does your health problem occur: Occasionally Intermittently Constantly Frequently

Have you had this problem before? ________________________ When? ___________________________

What aggravates your health problem? Coughing Sneezing Walking Reaching

Lifting Bending Sitting Lying Down Standing Neck Movement

Straining at Stool/Office Chair Other ____

What relieves your health problem? (Please circle all that apply) Nothing Resting

Sitting Standing Heat Ice Others ____________________

Have you had recent treatment for this condition? ___Yes ___No

If so, who did you see? ___________________________Treatment ________________________________

WHAT ARE YOUR HABITS?

Smoking	never	packs per day _____
Alcohol	never	drinks per day ____
Caffeinated drinks	never	drinks per day ____
Exercise	never	times per week____
Drug/Substance Abuse	never	yes___if yes, discuss with your doctor

Vitamins/herbs (list all being taken): ____

MEDICAL HISTORY

Have you seen a doctor of chiropractic? ___Yes ___No

Who is your Family Physician? ___________________Date of last physical exam: ___________________

Do you give us permission to send your family doctor your progress and treatment notes? __Yes __No

Have you been hospitalized in the past 5 years? __Yes __No Date and reason, if yes: _____________
____

HEALTH INFORMATION AND HEALTH HISTORY

MEDICAL HISTORY

Have you had any serious accidents in the past 5 years: __Yes __No Date and Describe, if yes: ____
____

List any broken bones or dislocations: ____

Have you ever had a spinal tap or injection? __ Yes __ No
Have you even been knocked unconscious? __ Yes __ No
Have you ever had a lapse in memory? __ Yes __ No
Have you ever had x-rays, MRI or CAT Scan of your spine? __ Yes __ No When? ________________

Do you suffer from any condition other than that for which you are consulting us?
____

Please list your medications: ____

Ladies: Please check any that apply. Taking Birth Control___ Pregnant___ Nursing___

In the past 6 months have you had any of the following? (Please place an “x” for all that apply)

	Appendicitis		Heart Disease		Pneumonia
	Polio		Diabetes		Rheumatic Fever
	Anemia		Arthritis		Epilepsy
	Tuberculosis		Hypertension		HIV/AIDS
	Cancer		Alcoholism		

Please place an "x" for all symptoms that currently apply to you.

GENERAL SYMPTOMS	GASTRO-INTESTINAL	EARS, EYES, NOSE, THROAT	RESPIRATORY
__ Headaches	__ Poor appetite	__ Poor vision	__ Cough
__ Fever	__ Poor digestion	__ Pain in eyes	__ Short of breath
__ Night sweats	__ Excessive hunger	__ Deafness	

__ Fainting	__ Belching or gas	__ Earache	**GENITO-URINARY**
__ Dizziness	__ Nausea	__ Ear noises	__ Frequent urination
__ Convulsions	__ Vomiting	__ Nosebleeds	__ Painful urination
__ Loss of sleep	__ Stomach pain	__ Sore throat	__ Blood in urine
__ Fatigue	__ Constipation	__Sinus Trouble	__ Kidney infections
__ Loss of weight	__ Diarrhea	__ Hay fever	__ Bed wetting
__ Allergies	__ Hemorrhoids	__ Asthma	__ Incontinence
__ Weakness	__ Liver trouble	__ Frequent colds	__ Prostate trouble
__ Twitching	__ Jaundice	__ Thyroid trouble	__ Bladder infections
	__Gall bladder	__Tonsillitis	
MUSCLE AND JOINTS	**CARDIOVASCULAR**	**SKIN**	**FOR WOMEN ONLY**
__ Stiff neck	__ Rapid heartbeat	__ Itching	__Painful Periods
__ Neck pain	__ Slow heartbeat	__ Bruise easily	__Excessive Flow
__ Middle back pain	__ High blood pressure	__ Dry skin	__ Irregular cycles
__ Lower back pain	__ Chest pain	__ Boils	__ Hot flashes
__ Arm pain	__ Swollen ankles	__ Sensitive skin	__ Cramps
__ Arm numbness	__ Poor circulation	__ Hives	__ Vaginal discharge
__ Leg pain	__ Varicose veins	__ Eczema	__ Currently pregnant
__ Leg numbness	__ Stroke		__ Breast implants
__ Swollen joints	__ Heart attack		Date of last PAP: ______
__ Painful tailbone			
__ Foot pain			
__Spinal curvature			

Have you ever had any of the following surgeries? If yes, please list date.

__ Tonsillectomy	_________	__ Gall bladder	_________	__ Hernia	_________
__ Tubes in ears	_________	__ Stomach	_________	__ Cataract	_________
__ Sinus	_________	__ Appendectomy	_________	__ Vision correction	_________
__ Thyroid	_________	__ Female organs	_________	__ Breast reduction	_________
__ TMJ	_________	__ Hemorrhoids	_________	__ Mastectomy	_________
__ Neck	_________	__ Back	_________	__ Prostate	_________

FAMILY HISTORY

Has any member of your family had any of the following diseases?

___ Diabetes ___ Arthritis ___ Heart Trouble ___ Cancer

Do any family members suffer from the following: Please place an “x” for all that apply.

___Neck Problems ___Back Problems ___Headaches ___Arthritis

___Disc Problems ___Pinched Nerves ___Scoliosis ___Osteoporosis

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Doctor’s Signature:___________________________________ Date:________________________

For Office Use Only: Height_________________ Weight______________________

Pulse__________________ Blood Pressure________________

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. 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 and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
I hereby authorize the doctor to examine me and treat my condition as he or she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. The doctor will not be held accountable for any pre-medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: ________________________________ Date: ____________

INFORMED CONSENT FOR CHIROPRACTIC CARE

A Patient, in coming to the Doctor of Chiropractic, gives the doctor permission and authority to care for the patients 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 Doctor of Chiropractic. The Doctor of Chiropractic 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 doctor at **Back, Body & Beyond 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.

Parent Signature: ________________________________ Date: ______________

PATIENT PRIVACY 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 affect 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.
8. From time to time we may send you birthday cards or letters, use your name on a birthday list or use your name in a referral binder in our office. By your signature below you have given us permission to do so.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: ___________________________________Date: ____________________

Dr. Steven J. Abro, D.C.
901 Dupont Road, Ste. 102
Louisville, KY 40207
Telephone: (502) 618-3745
Fax: (502) 618-3746
www.backbodyandbeyondchiro.com

CONSENT FOR TREATMENT

I, THE UNDERSIGNED, HEREBY AUTHORIZE DR. STEVEN J. ABRO AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS TO PERFORM AND ADMINISTER THERAPY AND TREATMENT AS IS NECESSARY. I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAD BEEN MADE TO THE RESULTS THAT MAY BE OBTAINED.

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANAGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERESTAND THAT THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON REQUEST. I PERMIT THIS OFFICE TO ENDORSE REMITTANCES FOR THE CONVEYANCE OF CREDIT TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

PATIENT SIGNATURE: ___________________________ DATE: ______________

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, DEMAND, & CERTIFICATION

Insurer and Patient Please Read the Following in its Entirety

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (P.I.P.), Workman's Compensation and General Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

In the event the subject medical benefits are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e. to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute. If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this agreement is to be considered as valid as the original.

I agree to pay any applicable deductible, co-payment, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident.

The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider.

Release of Information: I hereby authorize this provider to: furnish the insurer, an insurer's intermediary and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer request from the insurer all EOB's from all providers and non-redacted PIP payout sheets; obtain copies of all medical records, including but not limited to, documents, records, scans, notes, bills, opinions, X-rays, IME's, and MRI's, from any other medical provider or any insurer. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days.

Certification: I certify: that I have not been solicited or promised anything in exchange for receiving health care; that I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment; and that I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name______________________________ (Please Print)

Patient's Signature______________________________ (If patient is a minor, signature of parent/guardian)

Date: ________________________

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Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

______________________________ ______________________

Signature Date