Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Patient Name__________________________ Date_______________

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _______ day of _______________________, 20___

By_____________________________________
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By:___________________________________
Signature of Parent/Guardian (circle one)

7205 Vista Dr Suite 104 -- West Des Moines, IA 50266 -- 515.225.9200 -- www.optimumchiro.com

PATIENT QUESTIONNAIRE

PATIENT INFORMATION

Legal Name_________________________________ How would you like to be addressed?______
Address:_____________________________________ City:___________ State:_____ Zip:______
Cell Phone:__________________ Cell Carrier:___________ Home Phone:____________________
Email:____________________________ SSN#:____-____-_____ Date of Birth:____/____/______

Male Female Marital Status: Single Married Widowed Divorced

How did you hear about our office?

Optimum Chiropractic Website Search Engine:________

Community Event:__________ Law Firm:__________ Lunch and Learn:_________

Patient Referral - who can we thank for sharing the benefits of care with you?_____________

Have you ever had Chiropractic Care? Yes No

If yes, please tell us the doctor's name and when care occurred:___________________________

Were you pleased with your care? Yes No

Are you receiving care from other health care professionals? Yes No

If yes, please name them and their specialty:____

Who is your family's primary care physician:____

Optimum Chiropractic believes that health care is a team effort. May we have your permission to update your medical doctor regarding your care at this office? Yes No

Please list any medications, herbs, supplements, homeopathics or other remedies you are currently taking:

____

____

INSURANCE

Have you provided our office with a copy of your insurance card? Yes No

How are you insured? (Please check all that apply)

Individual Policy Through Employer Medicaid (Title 19) Medicare

If policy holder is someone other than the patient, please provide:

Policy Holder Name:______________________________ Date of Birth: _____/_____/______

Relationship to Patient:____________________________ SSN:______-____-__________

NOTICE OF 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 payors 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.

AUTHORIZATION

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. The following person(s) have my permission to receive my personal health information:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient:_______________________________________**Date:**________________________________

Signature of Patient/Legal Guardian:____

FAMILY & SOCIAL HISTORY & REVIEW OF SYSTEMS

How often do you drink alcoholic beverages?___________ Do you smoke? Yes, how much?_____ No

Do you exercise? Yes No How often?___________ Type?_________________________________

Female: Are you currently pregnant? Yes No Date of last menstrual cycle?_________________

Check those involving family and include identification: **M = mother, F = father, S = sibling, G = grandparent**

Cancer, type________	**Depression**	**Diabetes**	**Back Problems**
M F S G	M F S G	M F S G	M F S G
Heart Disease	**Liver Disease**	**High Blood Pressure**	**High Cholesterol**
M F S G	M F S G	M F S G	M F S G
Lung Problems	**Scoliosis**	**Neck Problems**	**Osteoporosis**
M F S G	M F S G	M F S G	M F S G
Seizures	**Osteoarthritis**	**Rheumatoid Arthritis**	
M F S G	M F S G	M F S G	

Do you have any of the following:

Constitutional: fever, chills, night sweats, loss of appetite, unexplained weight loss/gain *Yes* *No*

*Office Use:*____

Eyes/Vision: cataracts, blindness, double vision, light sensitivity, blind spots, tearing, non-allergy based itching, burning or dryness *Yes* *No*

*Office Use:*____

Ears, Nose & Throat: fainting, history of head injury, runny nose, dizziness, frequent sore throats, loss of smell or hearing, chronic sinus infections, ear discharge or pain, nosebleeds *Yes* *No*

*Office Use:*____

Respiration: cough, shortness of breath, wheezing, asthma, coughing up blood or sputum *Yes* *No*

*Office Use:*____

Cardiovascular: high or low blood pressure, varicose veins, shortness of breath laying down or with exertion, heart murmur, palpitations, ulcers *Yes* *No*

*Office Use:*____

Gastrointestinal: belching, difficulty swallowing, abdominal pain, black/tarry stools, heartburn, ulcers, constipation or diarrhea, hemorrhoids, rectal bleeding *Yes* *No*

*Office Use:*____

Female: Frequent urination, abnormal discharge, breast lumps or pain, abnormal cramping *Yes* *No*

*Office Use:*____

Male: Burning or frequent urination, prostate issues, ED, hesitancy or urine retention *Yes* *No*

*Office Use:*____

CHIROPRACTIC

Do you know what a subluxation is? Yes No

Do any of your friends or relatives see a chiropractor? Yes No

If yes, do they use chiropractic for Health Maintenence/Optimimzation Health problems Both

Are you seeking chiropractic for Health Maintenence/Optimimzation Health problems Both

Are you aware of the massive benefits of chiropractic care for children? Yes No

What would you like to gain from chiropractic care?____

____

OFFICE USE ONLY

Doctor signature indicates that the PFSH and ROS was verbally reviewed with the patient during consultation

*Doctor signature:*____________________________________ *Date:*________________

HEALTH HISTORY

What health condition brings you to our office:____

Indicate the current **intensity** of your complaint:

Mild | Severe

1	2	3	4	5	6	7	8	9	10

Indicate the **percentage** of daytime it is present:

None | All Day

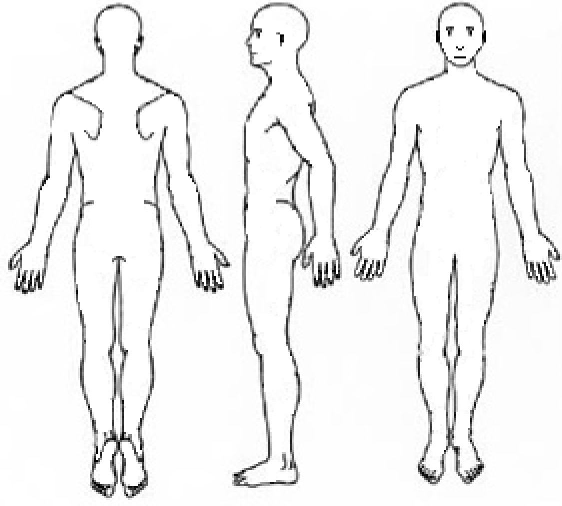
10	20	30	40	50	60	70	80	90	100

How **long** have you been experiencing your main complaint?______________________________________

Has the intensity **ever** been at a level of 9 or 10? Yes No

Using the letters below, please show where you are experiencing all of your current complaints:

A=Ache **B**=Burning **ST**=Stabbing **C**=Cramping **N**=Numbness **P**=Pins and Needles **T**= Throbbing



What makes it feel **better**:____________________________

____

What makes it feel **worse**:____________________________

____

Does this affect your work or other activities:

- Decision making
- Unable to work
- Decreased productivity
- Poor attitude
- Exhausted at end of day
- Other:_________________

Does this affect your life:

- Lose patience with spouse or children
- Restricted household duties
- Hinders ability to exercise/play sports
- Hinders ability to participate in hobbies/recreation

DAILY ACTIVITIES

Does your condition limit your ability to **DRIVE**?

Unable to drive due to pain | Able to drive 60 minutes | 30 minutes | 10 minutes | No limitation

Does your condition limit your ability to **CARRY** objects?

Unable to carry any weight | Can carry heavy objects | Moderate objects | Light objects | No limitation

Does your condition limit your ability to **SLEEP**?

Unable to sleep | Loss of 3-5 hours | Loss of 2-3 hours | Loss of 1-2 hours | No limitation

Does your condition limit your ability to **STAND**?

Unable to stand | Able for <10 minutes | 15 minutes | 30 minutes | 60 minutes | No limitation

Does your condition limit your ability to **SIT**?

Unable to sit | Able for 1 hour | Able for 2 hours | Able for 4 hours | Able for 8 hours | No limitation

Does your condition limit your ability to go from **SITTING TO STANDING**?

Unable without help | Able from high chair | Recliner | Medium chair | Low chair | No limitation

Does your condition limit your ability to **WALK**?

Unable to walk | No more than 10 feet | 100 feet | ½ mile | 1 mile | No limitation

Does your condition limit your ability to perform **HOUSEWORK**?

Unable to do housework | Able to do <10 minutes | 15 minutes | 30 minutes | 60 minutes | No limitation

Does your condition limit your ability to **BEND**?

Unable to bend | Can bend ¼ of the way | Can bend halfway | Can bend ¾ of the way | No limitation

In the event that we can help, what is your level of commitment to correcting your problem(s)?

LOW | **MEDIUM** | **HIGH**

1	2	3	4	5	6	7	8	9	10

I acknowledge that the above information is true and accurate to the best of my knowledge

Patient Signature:______________________ **Patient name:**______________________ **Date:**______________