

**CONNER CHIROPRACTIC, LLC**  
**Confidential Patient Health Information**

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**Personal Information:**

Mr.  Mrs.  Miss Name: \_\_\_\_\_ Age: \_\_\_\_  M  F  
Address: \_\_\_\_\_ City/ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Drivers License #: \_\_\_\_\_ Marital Status: \_\_\_\_  
Home Phone: ( ) \_\_\_\_-\_\_\_\_ Work Phone: ( ) \_\_\_\_-\_\_\_\_ X\_\_\_\_ Other Phone ( ) \_\_\_\_-\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_  
Nearest Relative: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_-\_\_\_\_  
E-mail address (for Patient newsletter): \_\_\_\_\_  
HOW WERE YOU REFERRED? \_\_\_\_\_

**Reason for your Visit:**

Have you been to this clinic before?  Yes  No  
Purpose of this appointment \_\_\_\_\_  
Reason for your visit is a result of (please circle): work injury, auto accident, trauma, chronic problem, other  
Please describe the pain and its location: \_\_\_\_\_  
Date of accident/injury, or when condition began: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Is condition getting worse?  Yes  No  Staying the Same  Comes and goes  
Is this condition interfering with your:  Work  Sleep  Daily Routine  Other  
Have you been treated by another doctor for this condition?  Yes  No  
If yes, please name doctor/health care facility: \_\_\_\_\_

**Insurance Information:**

Company Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_-\_\_\_\_  
Address: \_\_\_\_\_ City/ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insured ID (if different than SS#): \_\_\_\_\_ Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Policy/Group #: \_\_\_\_\_ Plan Name: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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### Your Health History (circle "C" if the problem is a current one and "P" if you've had the problem in the past)

#### General

C P Allergy  
C P Convulsions  
C P Fatigue  
C P Fainting  
C P Headache  
C P Sudden Weight Loss  
C P High Blood Pressure

#### Muscle & Joint

C P Arthritis  
C P Bursitis  
C P Low Back Pain  
C P Neck Pain/Stiffness  
C P Shoulder Pain  
C P Spinal Curvature  
C P Midback Pain

#### Eyes, Ears Nose & Throat

C P Hearing Loss  
C P Ear-ache  
C P Failing Vision  
C P Nosebleeds  
C P Sinus Infections  
C P Strep Throat  
C P Thyroid Problems

#### Gastrointestinal

C P Colon Problems  
C P Constipation  
C P Diarrhea  
C P Gall Bladder  
C P Hemorrhoids  
C P Hernia  
C P Liver Problems

#### Vascular

C P Nausea/Vomiting  
C P Dizziness  
C P Numbness on one side  
of the face or body  
C P Difficulty Swallowing  
C P Difficulty Walking  
C P Difficulty Speaking  
C P Fainting/Light Headed  
C P Double Vision  
C P Rapid Eye Movement  
C P Neck or Head Pain  
Like Never Before

#### Pain or Numbness

C P Shoulders/Arms  
C P Elbows/Hands  
C P Hips/Legs  
C P Ankles/Knees/Feet

#### Skin Problems

C P Bruise Easily  
C P Hives or Allergic Reaction  
C P Skin Rash  
C P Acne

#### Respiratory

C P Asthma  
C P Chest Pain  
C P Chronic Cough  
C P Spitting up Blood

#### Genito-Urinary

C P Bedwetting  
C P Frequent Urination  
C P Kidney Infection  
C P Painful Urination  
C P Prostate Trouble  
C P Kidney Stones

#### For Women Only

C P Cramps or Backache w/cycle  
C P Excessive Menstrual Flow  
C P Irregular Cycles  
C P Lumps in Breast  
C P Pain w/intercourse  
C P Pelvic Inflammatory Disease

#### Other

C P Stroke  
C P Rheum.Fever  
C HIV/AIDS  
C P Alcoholism  
C P Diabetes  
C P Cancer

Please list any medications you are taking, (including OTC) \_\_\_\_\_

Please list any medications that you are allergic to: \_\_\_\_\_

Please list all surgeries and dates \_\_\_\_\_

Medical Physician's name \_\_\_\_\_

### Your Family History (some health problems are the result of familial tendencies)

Family Member                      Illnesses                      Age    (or)    Age Died                      Cause of Death

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brother(s) \_\_\_\_\_

Sister(s) \_\_\_\_\_

### Social History

Do you smoke?  Yes  No If yes, how many packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you consume alcoholic beverages?  Yes  No If yes, socially? Moderately? Daily? Rarely?

Do you exercise regularly?  Yes  No If yes, daily? 3x/week 1x/week Other (specify): \_\_\_\_\_

### In the event of an emergency...

Who should we contact? \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone #: (    ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone #: (    ) \_\_\_\_\_ - \_\_\_\_\_ X \_\_\_\_\_

# **CONNER CHIROPRACTIC, LLC**

## ***Confidential Patient Health Information***

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### **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 compliance officer 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 compliance officer 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.

### **Informed Consent for Chiropractic Spinal Manipulation, Diagnostic X-Rays and Treatment, Authorization and Release**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities (including but not limited to ultrasound, muscle stimulation, interferential, ice, heat, traction, spinal decompression) and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by or under the orders of the licensed doctors of chiropractic of Conner Chiropractic or any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications and realize that alternatives to care might include medical treatment, surgery or doing nothing. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment of insurance benefits directly to Conner Chiropractic. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Conner Chiropractic to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand and agree 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 the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

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

I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_

**Consent to Treatment of a Minor Child:**

I hereby authorize the doctors of Conner Chiropractic, and/or whomever they may designate as assistants, to administer treatment as deemed necessary to \_\_\_\_\_.

Signature of Parent or Legal Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness signature: \_\_\_\_\_

***It is usual and customary to pay for services as rendered unless otherwise arranged.***