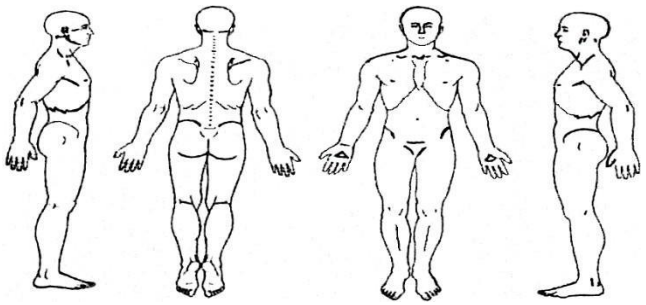
Patient History

Legal Name: _____ **Date of Birth:** _____/_____/_____

ROF Doctor: _____

Condition/Problem	Severity Minimal Severe		Frequency (% of the week) Occasional Constant
a.	1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100
Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles			
b.	1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100
Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles			
c.	1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100
Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles			
d.	1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100
Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles			
e.	1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100
Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles			

Please mark the figures where you experience pain.



1. Symptoms are <u>worse</u> in the (mark what applies)

   ___Morning ___Increase during the day

   ___Afternoon ___Same all day

   ___Night ___Decrease during the day

2. Do your symptoms radiate? Yes / No

3. Your condition has:

   ___ Improved ___ Gotten Worse ___ Stayed the same since it began

4. Mark the things that make your symptoms <u>worse</u>:

__Bending __Lying __Walking __Standing __Sitting __Movement __Twisting __Lifting __Sleeping

5. Is there anything that you can do to relieve the symptoms? Yes / No

   Describe. If no, what have you tried that did not help? _____

6. List any other major accidents you have had:

   _____

7. When was the last time you were adjusted? _____

8. What is your occupation? _____

Staff Only:			
Height (inches)	**Weight**	**Pulse**	**BP (L / R)**

Accident/Injury Information

Legal Name: _____ Date of Birth: ____/____/_____

Date of Accident: _____ / _____ / _____	Time of Accident: _____: _____ AM PM
Patient's Vehicle Speed: _____ MPH	Other Vehicle's Speed: _____ MPH

Patient's position was:

____ Driver ____ Front Center ____ Front Right ____ Rear Left ____ Rear Center ____ Rear Right

Damage to patient's vehicle:

___ Mild ___ Moderate ___ Extensive ___ Totaled

Who hit who/what?

___ Patient hit another vehicle ___ Another vehicle hit patient ___ Patient hit object
What object? _____

Weather conditions:

___ Clear ___ Raining ___ Snowing ___ Foggy ___ Windy ___ Icy

Visibility was:

___ Good ___ Fair ___ Poor

Point of impact

____ Front Left ____ Front Center ____ Front Right ____ Left Side

____ Rear Left ____ Rear Center ____ Rear Right ____ Right Side

Was the patient using a seatbelt?	____ Yes	____ No
Was the patient braced for impact?	____ Yes	____ No
Was the patient wearing the shoulder harness?	____ Yes	____ No
Did the vehicle have an airbag?	____ Yes	____ No
Was the airbag deployed?	____ Yes	____ No
Did the patient strike anything in the vehicle?	____ Yes	____ No

If yes, what?

___ Airbag ___ Steering Wheel ___ Dashboard ___ Gear shift ___ Rearview Mirror ___ Seat Back
___ Headrest ___ Rear Window ___ Armrest ___ Roof ___ Side door ___ Side Window

Was the head injured?	____ Yes	____ No	
Was the patient dazed?	____ Yes	____ No	
Did the patient lose consciousness?	____ Yes	____ No	If yes, for how long? _____

Direction of the head:

___ Turned to the right ___ Facing straight forward ___ Turned to the left

Immediately after the accident the patient experienced:

___ Headaches ___ Neck Pain ___ Low Back Pain

Patients condition is:

___ Improving ___ Staying the same ___ Getting worse

Legal Name: _____ Date of Birth: ____/____/_____

Other part(s) injured? Please indicate and explain
Bruises: _____
Abrasions: _____
Lacerations: _____
Swelling: _____
Bleeding: _____
Fracture: _____
Burns: _____
Other: _____

Did the patient go to the hospital?	____ Yes	____ No	Which Hospital? _____	
Transportation to the hospital:				
___ Self	___ Somebody else	___ Police	___ Ambulance	___ Helicopter
Tests done at hospital:				
___ Lab Work	___ MRI	___ X-rays	___ CT-Scan	

Has the patient lost time from work?	____ Yes	____ No	If yes, how much time? _____
Can patient perform physical activities?	____ Yes	____ No	
If no, why?	___ Pain	___ Stress	___ Weakness

Patient is having problems with: Mark all that apply				
____ Seeing	____ Tasting	____ Smelling	____ Eating	____ Hearing
____ Bathing	____ Grooming	____ Dressing	____ Reading	____ Typing
____ Writing	____ Grasping	____ Holding	____ Pinching	____ Standing
____ Leaning	____ Memory	____ Stooping	____ Squatting	____ Climbing
____ Kneeling	____ Bending	____ Twisting	____ Carrying	____ Lifting
____ Pushing	____ Using the toilet	____ Reaching	____ Sitting	____ Driving
____ Car Travel	____ Air Travel	____ Sports	____ Exercising	____ Walking
____ Reclining	____ Restful Sleeping	____ Insomnia	____ Pulling	____ Nervousness
____ Irritability	____ Concentration	____ Loss of sexual drive		
____ Other (Please list):				

Staff Only:			
Height (inches)	**Weight**	**Pulse**	**BP (L / R)**

Family History

Legal Name: _____ Date of Birth: _____/_____/_____

Please mark all current health problems of family members.

Condition	Self	Father Age [ ]	Mother Age [ ]	Brother(s) Age(s) [ ]	Sister(s) Age(s) [ ]	Children Age(s) [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

Past Surgeries? Yes / No If Yes, please list: _____

Are you currently taking any medications? Yes / No

If Yes, Please list: _____

Any allergies? Yes / No If Yes, please list: _____

Demographics

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ SS#: _____

Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____

Email: _____

General Information

Family Physician: _____ Physician's Location: _____

Physician's Phone #: _____ May we send our findings to them? Yes / No

Emergency Contact: _____ Phone: _____ Relation: _____

Was the patient at fault? Yes / No
Do you have an attorney? Yes / No

If Yes, please fill in below:

Attorney's Name:	
Attorney's Number:	

If no attorney:

Claim Number	
Adjuster's Name	
Adjuster's Number	
Insurance Company	
Agent Name	
Agent Phone Number	

Signature: _____ Date: _____

DOCTOR'S LIEN

I do hereby authorize the above doctor to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against all proceeds of any settlement, judgment, or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Dated: _____ Patient's Signature: _____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Dated: _____ Signature: _____

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

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.

Patient Name _____ Patient Signature _____

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

Name of Parent/Guardian _____ Signature of Parent/Guardian _____

HIPAA AUTHORIZATION FOR FAMILY/FRIENDS

I, _____, give permission to DeTray Chiropractic Center providers and payers to disclose and release my health information to:

Names:	Relationship:
_____	_____
_____	_____
_____	_____

Health information to be disclosed: My complete health record (including but not limited to diagnoses, x-rays, prognosis, treatment, and billing for all conditions). This information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultations, for claims payment purposes, or related reasons. This authorization shall be effective all past, present, and future periods unless I revoke it. (Note: You may revoke this authorization in writing at any time)

Patient Name _____ Date of Authorization _____

Name of the individual giving this authorization _____

Signature of the individual giving this authorization _____

Privacy Policy

This privacy policy discloses the privacy practices for www.detraychiropractic.com. This privacy policy applies solely to information collected by this web site. It will notify you of the following:

1. What personally identifiable information is collected from you through the web site, how it is used and with whom it may be shared.
2. What choices are available to you regarding the use of your data.
3. The security procedures in place to protect the misuse of your information.
4. How you can correct any inaccuracies in the information.

Information Collection, Use, and Sharing

We are the sole owners of the information collected on this site. We only have access to/collect information that you voluntarily give us via email or other direct contact from you. We will not sell or rent this information to anyone.

We will use your information to respond to you, regarding the reason you contacted us. We will not share your information with any third party outside of our organization, other than as necessary to fulfill your request, e.g. to ship an order.

Unless you ask us not to, we may contact you via email in the future to tell you about specials, new products or services, or changes to this privacy policy.

Your Access to and Control Over Information

You may opt out of any future contacts from us at any time. You can do the following at any time by contacting us via the email address or phone number given on our website:

- See what data we have about you, if any.
- Change/correct any data we have about you.
- Have us delete any data we have about you.
- Express any concern you have about our use of your data.

Security

We take precautions to protect your information. When you submit sensitive information via the website, your information is protected both online and offline.

While we use encryption to protect sensitive information transmitted online, we also protect your information offline. Only employees who need the information to perform a specific job (for example, billing or customer service) are granted access to personally identifiable information. The computers/servers in which we store personally identifiable information are kept in a secure environment.

Updates

Our Privacy Policy may change from time to time and all updates will be posted on this page.