

# Confidential Patient Health Record

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you hear about us?  Family \_\_\_\_\_  Friend \_\_\_\_\_  Co-Worker \_\_\_\_\_  
 Close to home/work  Dr. \_\_\_\_\_  Yellow pages  Drove by  Insurance Plan  Other: \_\_\_\_\_

## Personal Information

Title:  Mr.  Ms.  Mrs.  
Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Suffix:  Jr  Sr  II  III  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female SSN: \_\_\_\_\_  
Marital Status:  Single  Married  Widowed  Divorced  Separated  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email Address: \_\_\_\_\_ Spouses Name: \_\_\_\_\_  
Children (Names and Ages): \_\_\_\_\_

## Emergency Contact

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

## Employment Information

Business Name: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Occupation/Job Title: \_\_\_\_\_ Job Description \_\_\_\_\_

## Current Health Condition

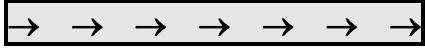
Unwanted Condition (Why you are here today?): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness  
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? \_\_\_\_/\_\_\_\_/\_\_\_\_

Has it ever occurred before?  Yes  No. When? \_\_\_\_\_

Is the Condition:  Auto Related  Job Related  Home Injury

Slip or Fall  Lifting  Slept Wrong  Unknown Cause  Other

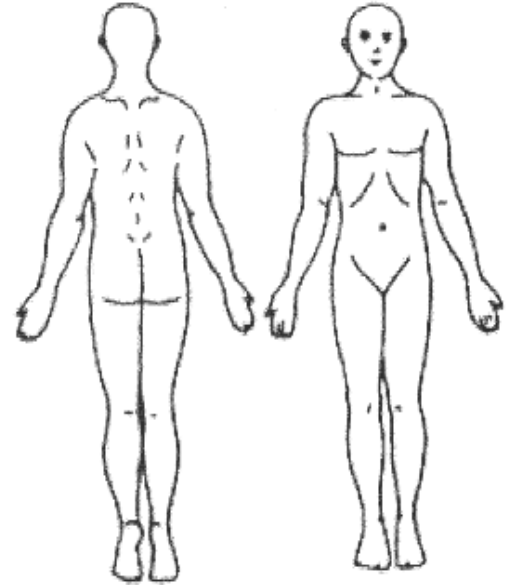
Explain: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am /pm

Condition/Pain STARTED on what Date: \_\_\_\_\_

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

\_\_\_\_\_  
\_\_\_\_\_



**REVIEW OF SYSTEMS** -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

**Constitutional:**  I DENY having or have had any of the symptoms or problems listed below.

- chills  fatigue  night sweats  weight loss
- daytime drowsiness  fever  weight gain

**Eyes/Vision:**  I DENY having any of the symptoms or problems listed below.

- blindness  change in vision  field cuts  photophobia
- blurred vision  double vision  glaucoma  tearing
- cataracts  eye pain  itching  wear glasses/contacts

**Ears, Nose and Throat:**  I DENY having any of the symptoms or problems listed below.

- bleeding  ear drainage  hearing loss  nosebleeds  sore throat
- dentures  ear pain  history of head injury  postnasal drip  ringing in ears
- fainting  difficulty swallowing  hoarseness  runny nose  TMJ problems
- discharge  frequent sore throats  loss of sense of smell  sinus infections
- dizziness  headaches  nasal congestion  snoring

**Respiration:**  I DENY having any of the symptoms or problems listed below.

- asthma  coughing up blood  sputum production
- cough  shortness of breath  wheezing

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Cardiovascular:**  I DENY having any of the symptoms or problems listed below.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> shortness of breath with exertion or exercise |
| <input type="checkbox"/> chest pain                        | <input type="checkbox"/> low blood pressure  | <input type="checkbox"/> swelling of legs                              |
| <input type="checkbox"/> claudication (leg pain/ache)      | <input type="checkbox"/> orthopnea (difficulty breathing lying down)                           | <input type="checkbox"/> ulcers  |
| <input type="checkbox"/> heart murmur                      | <input type="checkbox"/> palpitations  | <input type="checkbox"/> varicose veins                                |
| <input type="checkbox"/> heart problems                    | <input type="checkbox"/> paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath) |  |

**Gastrointestinal:**  I DENY having any of the symptoms or problems listed below.

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain       | <input type="checkbox"/> diarrhea              | <input type="checkbox"/> indigestion     | <input type="checkbox"/> abnormal stool caliber     | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching             | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice        | <input type="checkbox"/> abnormal stool color       |   |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn             | <input type="checkbox"/> nausea          | <input type="checkbox"/> abnormal stool consistency |   |
| <input type="checkbox"/> constipation         | <input type="checkbox"/> hemorrhoids           | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting                   |   |

**Female:**  I DENY having any of the symptoms/problems and/or using any of the items listed below.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> birth control     | <input type="checkbox"/> cramps             | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> vaginal bleeding  |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> frequent urination | <input type="checkbox"/> pregnancy              | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> burning urination | <input type="checkbox"/> hormone therapy    | <input type="checkbox"/> urine retention        |  |

**Male:**  I DENY having any of the symptoms or problems listed below.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> burning urination    | <input type="checkbox"/> frequent urination   | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/ dribbling | <input type="checkbox"/> urine retention   |

**Endocrine:**  I DENY having any of the symptoms or problems listed below.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> cold intolerance   | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> goiter           | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes           | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> hair loss        | <input type="checkbox"/> voice changes       |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> heat intolerance | <input type="checkbox"/> urinary problems |  |

**Skin:**  I DENY having any of the symptoms or problems listed below.

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss                 | <input type="checkbox"/> itching      | <input type="checkbox"/> skin lesions / ulcers |
| <input type="checkbox"/> changes in skin color   | <input type="checkbox"/> hives                     | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities          |
| <input type="checkbox"/> hair growth             | <input type="checkbox"/> history of skin disorders | <input type="checkbox"/> rash         |  |

**Nervous System:**  I DENY having any of the symptoms or problems listed below.

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> dizziness       | <input type="checkbox"/> limb weakness         | <input type="checkbox"/> numbness          | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremor                                |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> seizures          | <input type="checkbox"/> stress         | <input type="checkbox"/> unsteadiness of gait/ loss of balance |
| <input type="checkbox"/> headache        | <input type="checkbox"/> loss of memory        | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes        |  |

**Psychologic:**  I DENY having any of the symptoms or problems listed below.

- |   |  |                                      |                                      |
|---|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> anhedonia                  | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> anxiety                    | <input type="checkbox"/> bi-polar disorder | <input type="checkbox"/> depression  | <input type="checkbox"/> mood change |
| <input type="checkbox"/> loss or change in appetite | <input type="checkbox"/> confusion         | <input type="checkbox"/> insomnia    |                                      |

**Allergy:**  I DENY having any of the symptoms or problems listed below.

- |   |   |   |                                   |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> anaphalaxis      | <input type="checkbox"/> itching                | <input type="checkbox"/> chronic nasal congestion | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> acute nasal congestion | <input type="checkbox"/> rash                     |                                   |

**Hematologic:**  I DENY having any of the symptoms or problems listed below.

- |                                   |  |  |  |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> anemia   | <input type="checkbox"/> blood clotting    | <input type="checkbox"/> bruising easily | <input type="checkbox"/> lymph node swelling |
| <input type="checkbox"/> bleeding | <input type="checkbox"/> blood transfusion | <input type="checkbox"/> fatigue         |  |



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

- back injury
- broken bones
- disability (ies)
- fall (severe)
- fracture
- head injury (loss of consciousness)
- head injury (no loss of consciousness)
- industrial accident
- joint injury
- laceration (severe)
- motor vehicle accident
- soft tissue injury (mild)
- soft tissue injury (moderate)
- soft tissue injury (severe)
- other: \_\_\_\_\_

**Family History: Mark all that apply below. List M=mother, F=father, S=sibling, GF=grandfather, GM =grandmother**

- \_\_\_ High Blood Pressure \_\_\_ Heart Attack \_\_\_ Emphysema \_\_\_ Seizure-Convulsions
- \_\_\_ Ulcer/ Stomach problems \_\_\_ Asthma \_\_\_ Diabetes \_\_\_ Kidney Disease \_\_\_ Fibromyalgia
- \_\_\_ Stroke: if yes what age \_\_\_ \_\_\_ Arthritis-Rheumatism \_\_\_ Mental Illness \_\_\_ Thyroid Disease
- \_\_\_ Circulation Problems

**Social History**

- Alcohol:**  Never  Social Consumption only  Beer  Liquor  Wine \_\_\_ oz \_\_\_ glasses;  Day  Week  Month
- Diet (please mark all that apply):**  High Fat  High Fiber  High Protein  High Salt  
 Low Calorie  Low Carb  Low Fiber  Low Salt  Low Sugar
- Education (please mark the highest level completed):**  Preschool  Elementary  Middle  Junior High  Votech  
 In High School  Didn't Finish High School  High School Diploma  Post High School Classes  Assoc/Technical Degree  
 In College  College Degree  In Graduate School  Graduate Degree  Doctorate  Other: \_\_\_\_\_

- Drugs:**  Deny any illegal drug use  Deny use of IV drugs  Haven't used drugs since \_\_\_\_\_  Have used drugs for \_\_\_\_\_
- Tobacco:  Deny Tobacco Use  Do not smoke cigars, cigarettes or pipe  Live with a smoker  Quit smoking  
 Smoke; # packs \_\_\_\_\_ per  Day  Week  Month  Chew; # \_\_\_\_\_ cans per  Day  Week  Year

**Insurance Information:**

- Who Is Responsible For Your Bill?  YOU and... (mark appropriate box(es))  Myself ONLY
- Spouse  Worker's Comp  Auto Insurance  Medicare  Medicaid  Other (be specific): \_\_\_\_\_
- Personal Health Insurance Carrier: \_\_\_\_\_ Health ID Card #: \_\_\_\_\_
- Policy Holder's Name: \_\_\_\_\_ Group #: \_\_\_\_\_
- Policy Holder's Date of Birth: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Workers Compensation Injury / Auto / Personal Injury:**

- Have you filed an injury report with your employer?  Yes  No Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_ am/pm
- Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_
- Carriers Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Adjuster: \_\_\_\_\_
- Claim #: \_\_\_\_\_

**I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information (HIPPA forms).**

Patient Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Back On Track

Chiropractic Center, P.A.  
Melissa M. Loidolt, DC

## CONSENT TO CHIROPRACTIC TREATMENT

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I \_\_\_\_\_, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

**Soreness:** I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

**Dizziness:** Temporary symptoms like dizziness and nausea can occur but are relatively rare.

**Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

**Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

**Physical Therapy Burns:** Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

### Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

### Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

**Medications:** Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

**Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

**Surgery:** Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

**Nontreatment:** I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

**I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.**

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

\_\_\_\_\_ Signature of patient

\_\_\_\_\_ Signature of witness

\_\_\_\_\_ Date and time

**\*\*For Doctor Use Only\*\***

**PATIENT STATUS AT TIME OF INFORMED CONSENT PROCESS**

Based on my personal observations, medical history and direct conversation with the patient, I conclude that throughout the consent process the patient was:

- Of legal age     Oriented x 3     Coherent and lucid
- Disoriented as to     On prescription/OTC medication but unimpaired
- Proficient in understanding the English language
- Assisted in understanding by an interpreter (Interpreter's name: \_\_\_\_\_)
- Resolute in denying the use of alcohol and or recreational drug use prior to consent
- Unable to give legal consent
- Consent given thru legal guardian \_\_\_\_\_

Name

Relationship

Patient's questions (if any) and information supplied are as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_

I certify that the above accurately describes the above named patient's status during the informed consent process.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Doctor

BACK ON TRACK CHIROPRACTIC CENTER, PA

**PATIENT CONSENT  
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION  
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

\_\_\_\_\_ hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by e-mail.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

\_\_\_\_\_  
Name of Patient/Individual (Please print)

\_\_\_\_\_  
Signature of Patient/Individual

\_\_\_\_\_  
Signature of Legal Representative  
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness