ARCTIC CHIROPRACTIC
SEWARD

PATIENT INFORMATION

Name: _____ Birth Date:_____-_____-_____ Age:_____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address:_____ Home Phone:_____Mobile Phone:_____

Work Phone:_____ Social Security #: _____

Employer:_____Occupation:_____

How did you hear about our office? _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary:_____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin?_____When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

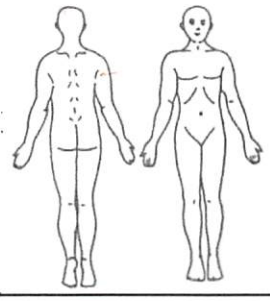
How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **Ifyes,** when:_____by whom? _____

How long were you under care:_____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

LIST RESTRICTED ACTIVITY:	**CURRENT ACTIVITY LEVEL:**	**USUAL ACTIVITY LEVEL:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes,** how many times?_____ When was the last episode?_____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment:_____, and who provided it:_____ **How long ago?**_____What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have or **N** for ***Never*** have had:

___ Broken Bone_____Dislocations ___Tumors ___Rheumatoid Arthritis_____Fracture _Disability_____Cancer
___ Heart Attack _Osteo Arthritis _ Diabetes _Cerebral Vascular ___Other serious conditions: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ☐Cigars ☐ Pipe ☐ Cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: Consumption Occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug Use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies -Recreational Activities- Exercise Regiment: How does your present problem affect? (See ADL form)

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐Yes
If yes whom: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Son(s) ☐ Daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐Yes: _____

_____ _____-_____-_____
Patient or Authorized Person's Signature **Date Completed**

_____ _____-_____-_____
Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME:_____ Date: _____

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances.

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public Health and Safety - to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government Agencies or Law Enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I have received a copy of the Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____ _____

Patient's Name DOB HR#

_____ _____

Patient's Signature Date

_____ _____

Witness Date

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

Carry Children/Groceries	O No Effect	O Painful (limits)	O Unable to Perform
Sit to Stand	O No Effect	O Painful (limits)	O Unable to Perform
Climb Stairs	O No Effect	O Painful (limits)	O Unable to Perform
Pet Care	O No Effect	O Painful (limits)	O Unable to Perform
Extended Computer Use	O No Effect	O Painful (limits)	O Unable to Perform
Lift Children/Groceries	O No Effect	O Painful (limits)	O Unable to Perform
Read/Concentrate	O No Effect	O Painful (limits)	O Unable to Perform
Getting Dressed	O No Effect	O Painful (limits)	O Unable to Perform
Shaving	O No Effect	O Painful (limits)	O Unable to Perform
Sexual Activities	O No Effect	O Painful (limits)	O Unable to Perform
Sleep	O No Effect	O Painful (limits)	O Unable to Perform
Static Sitting	O No Effect	O Painful (limits)	O Unable to Perform
Static Standing	O No Effect	O Painful (limits)	O Unable to Perform
Yard work	O No Effect	O Painful (limits)	O Unable to Perform
Walking	O No Effect	O Painful (limits)	O Unable to Perform
Washing/Bathing	O No Effect	O Painful (limits)	O Unable to Perform
Sweeping/Vacuuming	O No Effect	O Painful (limits)	O Unable to Perform
Dishes	O No Effect	O Painful (limits)	O Unable to Perform
Laundry	O No Effect	O Painful (limits)	O Unable to Perform
Garbage	O No Effect	O Painful (limits	O Unable to Perform
Driving	O No Effect	O Painful (limits)	O Unable to Perform
Other:	O No Effect	O Painful (limits)	O Unable to Perform

_____

_____

REVIEW OF SYSTEMS

Please mark **P** for **Past** **C** for **Currently have** **N** for **Never**

____ Headache	____ Dizziness	____Ulcers
____ Neck Pain	____ Loss of Balance	____ Heart Burn
____ Jaw Pain, TMJ	____ Fainting	____ Heart Problems
____ Shoulder Pain	____ Double Vision	____ High Blood Pressure
____ Upper Back Pain	____ Blurred Vision	____ Low Blood Pressure
____ Mid Back Pain	____ Ringing in Ears	____ Asthma
____ Low Back Pain	____ Hearing Loss	____ Difficulty Breathing
____ Hip Pain	____ Depression	____ Lung Problems
____ Back Curvature	____ Irritable	____ Kidney Trouble
____ Scoliosis	____ Mood Changes	____ Gall Bladder Problems
____ Numb/Tingling Arms, Hands, Fingers	____ ADHD	____ Liver Trouble
____ Numb/Tingling Legs, Feet, Toes	____ Allergies	____ Hepatitus

____ Currently Pregnant	____ Prostate Problems	____ Frequent Colds/Flu
____ Impotence/Sexual Dysfunction	____ Convulsions/Epilepsy	____ Digestive problems
____ Tremors	____ Colon Troubles	____ Chest Pain
____ Diarrhea/Constipation	____ Pain with Cough/Sneeze	____ Menstrual Problems
____ Foot or Knee Problems	____ PMS	____ Sinus/Drainage Problems
____ Bed Wetting	____ Swollen, Painful Joints	____ Learning Disability
____ Skin Problems	____ Eating Disorder	____ Trouble Sleeping

Signature _____ Date_____

PAIN SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ worst pain possible

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1 - What is your pain RIGHT NOW?

No pain _____ worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2 - What is your TYPICAL or AVERAGE pain?

No pain _____ worst pain possible

0 1 2 3 4 5 6 7 8 9 10

3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its BEST)?

No pain _____ worst pain possible

0 1 2 3 4 5 6 7 8 9 10

4 - What is your pain level AT ITS WORST (How close to "10" does your pain get at its WORST)?

No pain _____ worst pain possible

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

_____

_____

_____