Confidential Patient Health Record

***Today's Date*:____/_____/_____**

How did you hear about us? ☐ **Family** _____ ☐ **Friend** _____ ☐ **Co-Worker** _____
☐ **Close to home/work** ☐ **Dr.** _____ ☐ **Internet** ☐ **Drove by** ☐ **Insurance Plan** ☐ **Other**_____

Personal Information

Last:_____ **First:**_____ **Middle:** _____

Birth Date: ____ /____/_____ **Age:**_____ **Sex: Male / Female** **Social Security #:** _____-_____-_____

Blood Type: ☐ **A positive** ☐ **A negative** ☐ **B positive** ☐ **B negative** ☐ **AB positive** ☐ **AB negative** ☐ **O positive** ☐ **O negative**

Race: ☐ **African American** ☐ **Asian** ☐ **Caucasian** ☐ **Hispanic** ☐ **Multiracial** ☐ **Native American** ☐ **Other:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Eye Color: ☐ **blue** ☐ **brown** ☐ **green** ☐ **grey** ☐ **hazel** ☐ **other:** _____

Hair Color: ☐ **black** ☐ **blonde** ☐ **brown** ☐ **gray** ☐ **red** ☐ **white** ☐ **other:** _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____-_____ **ext** _____ **Work Phone:** (_____) _____-_____ **ext** _____

Cell Phone: (_____) _____-_____ **ext** _____ **Fax #:** (_____) _____-_____ **ext** _____

Email Address: _____ **Spouses Name:** _____

Children (Names and Ages): _____

Emergency Contact

Title: ☐ **Miss** ☐ **Mrs.** ☐ **Ms.** ☐ **Master** ☐ **Mr.** ☐ **Dr.** ☐ **Prof.** ☐ **Rev.** ☐ **other:** _____

Last:_____ **First:**_____ **Middle:** _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Birth Date: ____ /____/_____ **Email Address:** _____

Home Phone: (_____) _____-_____ **ext** _____ **Cell Phone:** (_____) _____-_____ **ext** _____

Work Phone: (_____) _____-_____ **ext** _____

Employment Information

Business Name: _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** (_____) _____-_____

Occupation/Job Title: _____ **Job Description** _____

Current Health Condition

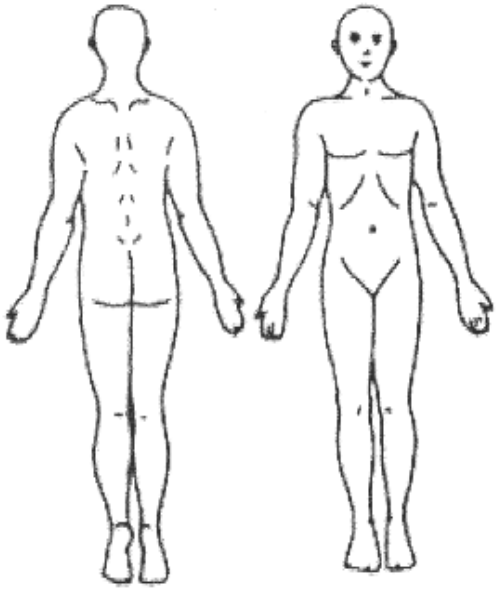
Unwanted Condition (Why you are here today?):_____

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

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 HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

☐ **chills**	☐ **fatigue**	☐ **night sweats**	☐ **weight loss**
☐ **daytime drowsiness**	☐ **fever**	☐ **weight gain**	

Eyes/Vision: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

☐ **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 HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

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

Respiration: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

☐ **asthma**	☐ **coughing up blood**	☐ **sputum production**
☐ **cough**	☐ **shortness of breath**	☐ **wheezing**

Cardiovascular: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

☐ **angina (chest pain or discomfort)**	☐ **high blood pressure**	☐ **shortness of breath with exertion or exercise**
☐ **chest pain**	☐ **low blood pressure**	☐ **swelling of legs**
☐ **claudication (leg pain/ache)**	☐ **orthopnea (difficulty breathing lying down)**	☐ **ulcers**
☐ **heart murmur**	☐ **palpitations**	☐ **varicose veins**
☐ **heart problems**	☐ **paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)**	

Gastrointestinal: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

□ abdominal pain	□ diarrhea	□ indigestion	□ abnormal stool caliber	□ vomiting blood
□ belching	□ difficulty swallowing	□ jaundice	□ abnormal stool color	
□ black - tarry stools	□ heartburn	□ nausea	□ abnormal stool consistency	
□ constipation	□ hemorrhoids	□ rectal bleeding	□ vomiting	

Female: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

□ birth control	□ cramps	□ irregular menstruation	□ vaginal bleeding
□ breast lumps/pain	□ frequent urination	□ pregnancy	□ vaginal discharge
□ burning urination	□ hormone therapy	□ urine retention	

Male: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

□ burning urination	□ frequent urination	□ prostate problems
□ erectile dysfunction	□ hesitancy/ dribbling	□ urine retention

Endocrine: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

□ cold intolerance	□ excessive hunger	□ goiter	□ unusual hair growth
□ diabetes	□ excessive thirst	□ hair loss	□ voice changes
□ excessive appetite	□ abnormal frequency of urination	□ heat intolerance	

Skin: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

□ changes in nail texture	□ hair loss	□ itching	□ skin lesions / ulcers
□ changes in skin color	□ hives	□ paresthesias	□ varicosities
□ hair growth	□ history of skin disorders	□ rash	

Nervous System: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

□ dizziness	□ limb weakness	□ numbness	□ slurred speech	□ tremor
□ facial weakness	□ loss of consciousness	□ seizures	□ stress	□ unsteadiness of gait/ loss of balance
□ headache	□ loss of memory	□ sleep disturbance	□ strokes	

Psychologic: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

□ anhedonia	□ behavioral change	□ convulsions	□ memory loss
□ anxiety	□ bi-polar disorder	□ depression	□ mood change
□ loss or change in appetite	□ confusion	□ insomnia	

Allergy: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

□ anaphalaxis	□ itching	□ chronic nasal congestion	□ sneezing
□ food intolerance	□ acute nasal congestion	□ rash	

Hematologic: **I HAVE or have had the symptoms or problems listed below: (please mark all that apply)**

□ anemia	□ blood clotting	□ bruising easily	□ lymph node swelling
□ bleeding	□ blood transfusion	□ fatigue	

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:
□ **I have not previously seen a doctor for this condition OR Fill in the information BELOW**

Have you seen other doctors for THIS CONDITION? □ Yes □ No. If yes, Who? (Name) _____
Type of Treatment: _____ Were you satisfied with the results of your treatment? □ Yes □ No

Explain: _____

Previous Chiropractic Care: □ **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ Location: _____ Date of Last Visit: _____
Were you satisfied with your care? □ Yes □ No. Why? _____

Do you wear any of the following? □ Heel Lifts □ Innersoles □ Arch Supports □ Orthotics □ Other_____

Current Medications/Vitamins/Herbs: **List ANY/ALL items you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Current diet

How many servings of fruits and vegetables do you eat each day?_____

How much soda pop do you drink each day?_____

Does your diet include animal products? YES/NO
If yes, what products and how often?_____

Childhood Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

- **ADD**
- **atopic dermatitis (eczema)**
- **allergies/hay fever**
- **anemia**
- **asthma**
- **bedwetting**
- **cerebral palsy**
- **chicken pox**
- **crohn's/colitis**
- **depression**
- **diabetes**
- **ear infections**
- **fetal drug exposure**
- **food allergies (list below)**
- **headaches**
- **hepatitis**
- **HIV**
- **measles**
- **mumps**
- **psoriasis**
- **rash**
- **scoliosis**
- **seizure disorder**
- **sickle cell anemia**
- **spina bifida**
- **other:**

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

Adult Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

- **ADD**
- **Alzheimer's**
- **anemia**
- **arthritis**
- **asthma**
- **cancer**
- **cerebral palsy**
- **chicken pox**
- **crohn's/colitis**
- **CRPS (RSD)**
- **CVA (stroke)**
- **cystic kidney disease**
- **depression**
- **diabetes (insulin dep)**
- **diabetes (non insulin)**
- **eczema**
- **emphysema**
- **eye problems**
- **fibromyalgia**
- **heart disease**
- **hepatitis**
- **HIV**
- **hypertension**
- **influenzal pneumonia**
- **liver disease**
- **lung disease**
- **lupus erythema (discoid)**
- **lupus erythema (systemic)**
- **multiple sclerosis**
- **Parkinson's disease**
- **unspecified pleural effusion**
- **pneumonia**
- **psoriasis**
- **psychiatric problems**
- **scoliosis**
- **seizures**
- **shingles**
- **past history of similar symptoms**
- **STD's (unspecified)**
- **suicide attempt(s)**
- **thyroid problems**
- **vertigo**
- **other:**

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

- **angioplasty**
- **appendectomy**
- **caesarian section**
- **cardiac catheterization**
- **carpal tunnel repair**
- **coronary artery bypass**
- **cosmetic**
- **D & C**
- **dental surgery**
- **gall bladder**
- **hemorrhoidectomy**
- **hernia repair**
- **hysterectomy**
- **joint reconstruction**
- **joint replacement**
- **knee repair**
- **laminectomy**
- **mastectomy**
- **pacemaker insertion**
- **rotator cuff**
- **spinal fusion**
- **tonsillectomy**
- **other:**

Females ONLY: Ob/Gyn **Mark all that apply below.**

If you have been pregnant in the past, please fill in the appropriate information below.

_____Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____Number of C-sections	_____Number of vaginal deliveries
_____ Number of miscarriages	_____Number of terminated pregnancies
I… □ am currently pregnant	□ am NOT currently pregnant

Menstrual History. _____ Age of first menses

I… □ currently have menses.	□ currently DO NOT have menses.
My menses… □ are regular.	□ are NOT regular.
Date of last menses: _____/_____/_____	_____Age when menopause began

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

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

Immunizations: **Please list the date(s) next to the immunization, if known.**

□ adenovirus	□ hepatitis C	□ pertussis	□ tuberculosis
□ anthrax	□ influenza	□ pneumococcal	□ tularemia
□ botulism	□ IPV (polio)	□ pneumovax	□ typhoid
□ diphtheria	□ Japanese encephalitis	□ PPD (mantoux test- TB)	□ varivax (chicken pox)
□ DTaP (diphtheria, tetanus, pertussis)	□ lyme disease	□ rabies	□ whooping cough (pertussis)
□ flu	□ measles	□ rotavirus	□ yellow fever
□ haemophilus B	□ meningococcal	□ rubella	□ other:
□ hepatitis A	□ MMR	□ smallpox	
□ hepatitis B	□ mumps	□ tetanus	

Non-Drug Allergies: **Mark all that apply below.**

□ adhesive tape	□ eggs	□ newsprint	□ shellfish
□ animals	□ feathers	□ nuts	□ smoke
□ bee sting	□ food coloring	□ peanuts	□ soap
□ chocolate	□ latex	□ perfumes	□ soy
□ dairy	□ mold	□ pollen	□ wheat
□ other:			

Label the NUMBER (#) of the TYPE of reaction you have to EACH allergy immediately AFTER the allergy above:

1. angioedema	3. GI disturbance	5. joint pain	7. shortness of breath
2. anaphylaxis	4. headache	6. rash	8. unspecified reaction

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

father	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has/had:_____
mother	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has/had:_____
paternal grandfather	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has/had:_____
paternal grandmother	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has/had:_____
maternal grandfather	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has/had:_____
maternal grandmother	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has/had:_____
son (s)	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has/had:_____
daughter(s)	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has/had: _____
brother(s)	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has/had: _____
sister(s)	□ alive	□ deceased	□ normally developed	□ no significant disease	□ has/had:_____

Social History: **Mark all that apply below.**

Alcohol: □ do not drink alcohol □ social consumption only □ drink the following regularly (mark below)
□ beer □ liquor □ wine; quantity of _____ oz./glasses per □ day □ week □ month

My Dietary Intake consists mainly of the following: (mark all that apply)

□ high fat	**□ high salt**	**□ low fiber**
□ high fiber	**□ low calorie**	**□ low salt**
□ high protein	**□ low carbohydrate**	**□ low sugar**

Mark the highest level of Education completed:

□ pre-school	**□ high school**	**□ college**	**□ doctorate**
□ elementary school	**□ high school graduate**	**□ college graduate**	**□ graduate school**
□ middle school	**□ GED**	**□ associates degree**	**□ graduate degree**
□ vocational school	**□ high school – incomplete**	**□ bachelors degree**	**□ other: _____**

Substance: □ never used illegal drugs □ has not used illegal drugs since _____ .
□ never used IV drugs □ used illegal drugs for _____ (how long?)

Tobacco: □ Do not use tobacco □ Do not smoke cigars, cigarettes or pipe □ Live with a smoker □ Quit smoking
□ Smoke: # ____ per □ Day □ Week □ Month; □ Chew: #_____cans per □ Day □ Week □ Year

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 #: _____

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 Social Security #: _____-_____-_____ Primary Care Physician: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

In the event I become delinquent (60 day after my appt) and payment is not made on the amounts owing under the terms of this agreement, and the balance is placed with a licensed collection agency, I agrees to pay the fees of the collection agency, which amount is therefore agreed to be 50% of the outstanding balance at the time the account is placed for collections. The 50% collection agency fee will be calculated and added at the time the account is placed into collections.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care and I have authority for these procedures to be performed. I, the patient, am responsible for all bills incurred at this office.

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: _____
Patient's Signature: _____ Date: _____
Consent to treat a Minor: _____ Date: _____
Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

BRIDGETOWER CHIROPRACTIC
CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

Patient's Name: (Print):_____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations and to obtain permanent records which may include x-rays and share and request records from other health care professionals as required for diagnosis, treatment planning, and post-treatment evaluation.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Debra F. Gibbons of Bridgetower Chiropractic, 3120 W Belltower Dr. Suite 150, Meridian, ID 83642

Telephone: (208) 846-8898 Fax: (208) 846-8920 e-mail: drscottgibbons@gmail.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations and to use or disclose my health information to another healthcare provider providing treatment to me.

Signature:_____ Date:_____
Patient or Parent of Minor

Signature:_____ Date: _____
Personal Representative/Interpreter

If this Consent is signed by a Parent, Personal Representative or Interpreter on behalf of the patient, complete the following:

_____ _____ _____
Print Name Relationship to Patient Phone

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.