



NEW PATIENT INFORMATION

PLEASE PRINT CLEARLY

Today's Date ____/____/20__

Date of Birth ____/____/____

Full Name: _____ Email: _____ Gender F M
 Address _____ City: _____ State _____ Zip _____
 Social Security #: ____ - ____ - ____ Driver's License #: _____ Home Phone# _____
 Marital Status: S M D W # of Children _____ Cell Phone# _____
 Last Menstrual Period: _____ Pregnant? Y N Nursing? Y N Work Phone# _____
 Work Status: FT PT Retired/Student
 Employer _____ Occupation _____
 Employer Address _____ City _____ State _____ Zip _____

Spouse/Parent/Guardian _____ Birth Date _____ SS#: ____ - ____ - ____
 Employer _____ Occupation _____ Work Phone# _____
 Home Phone# _____ Cell Phone # _____

In Case of an Emergency Contact: _____ Relationship: _____
 Home Phone# _____ Cell Phone # _____ Work Phone# _____

Name of Medical Physician _____

How did you hear about us? Whom may we thank for referring you?: _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you 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 PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow Idaho Chiropractic Group to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
- The patient has the right to examine and obtain a copy of his/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.
- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- The patient may provide a written request to revoke consent at any time during care. This would not affect 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.
- For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Idaho Chiropractic Group to assure that your records are not readily available to those who do not need them.
- Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- 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.

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

Print Patient Name

Patient/Parent/Guardian Signature

SURGICAL PROCEDURES:

TREATMENT: *What type of treatment are you looking for?*

- I am looking for the most minimal amount of care to “patch up the symptoms” of my problem.
- I am looking to resolve my symptoms and then go on to “fix the cause” of my problem.
- I am looking to take care of my problem and then go on to “achieve optimal health and wellness.”

COMPLAINT/PROBLEM: *In relation to your primary complaint:*

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: Y N
 If yes, whom? _____ Treatment(s): _____
 Have you had any intolerance or reactions to treatments? Y N Describe: _____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____ *Has it become worse recently?* Y N Same Better Gradually Worse

How frequent is the condition? Constant Daily Intermittent Night Only

How long does it last? All day Few hours Minutes

Is this condition interfering with your: Work Sleep Daily routine Recreation Other: _____

How long has it been since you really felt good? Days Weeks Months Years >10 years

What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other: _____

Is there anything that you can do to relieve the problem? Y N If yes, describe: _____

If no, what have you tried to do that has not helped? _____

Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? _____

Have you been in an auto accident? Past year Past 5 years Over 5 years Never

Describe: _____

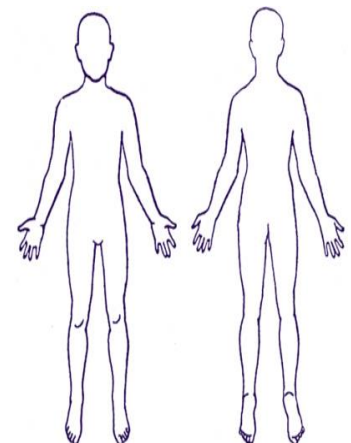
Please check all of the symptoms that apply. (P=Past/ C=Current)

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

- | | | |
|--|---|---|
| P/C | P/C | P/C |
| <input type="checkbox"/> Headache | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tingling in Feet |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Sore Muscles |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Weak Muscles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Fullness of Bladder | <input type="checkbox"/> Shakiness |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Urination Difficulty | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Impatience |
| <input type="checkbox"/> Unpleasant Taste | <input type="checkbox"/> Elbow/Hand Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Tingling in Hands | <input type="checkbox"/> Feel Loss of Control |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Clammy Hands | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lump in Throat | <input type="checkbox"/> Low Back Pain | _____ |
| <input type="checkbox"/> Swallowing Pain | <input type="checkbox"/> Hip Pain | _____ |
| <input type="checkbox"/> Unsteady Voice | <input type="checkbox"/> Knee Pain | |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Poor Circulation | |
| <input type="checkbox"/> Persistent Coughing | <input type="checkbox"/> Swollen Joints | |
| <input type="checkbox"/> Chest Pressure | <input type="checkbox"/> Joint Stiffness | |
| <input type="checkbox"/> Slow Heart Rate | <input type="checkbox"/> Swollen Ankles | |
| <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Ankle/Foot Pain | |

Stabbing/Cutting-///
 Burning-XXX
 Numbness-===

Tingling-:::
 Cramping-^^^
 Dull-###



HABITS:	Heavy	Moderate	Light	None		5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs	
Soda/Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		5+	4	3	2		
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meals/Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		64+ oz	32-64 oz	16-32 oz	<8 oz		
					Water/Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

WORK ACTIVITY: Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking/Moving Driving

FAMILY HISTORY: *Identify any conditions that you, or any of your family members have now or have had in the past:*
(G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

___ Alcoholism	___ Eczema	___ Miscarriage	___ Tumor(s)
___ Anemia	___ Emphysema	___ Mumps	___ Ulcer(s)
___ Cancer	___ Epilepsy	___ Pleurisy	___ Other: _____
___ Cold sores	___ Goiter	___ Pneumonia	_____
___ Deep vein thrombosis	___ Gout	___ Polio	_____
___ Detached retina	___ Heart Disease	___ Rheumatic fever	_____
___ Diabetes	___ HIV/AIDS	___ Stroke	_____

HIPPA ACKNOWLEDGEMENT

- I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF Idaho Chiropractic Group, PLLC's Privacy Notice that has an effective date of June 16, 2004. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Idaho Chiropractic Group to assure that your records are not readily available to those who do not need them.

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

 Print Patient Name Date

 Patient or Guardian Signature Date