File # _____

Date: _____

SPENCER CHIROPRACTIC & WELLNESS CENTER

Patient Health History

In order to provide you the best possible chiropractic care, please complete this form as accurately as possible. All information is CONFIDENTIAL.

PATIENT DATA & DEMOGRAPHICS

First Name _____ M.I. _____ Last _____ Nickname _____

Address _____ City _____ State _____ Zip _____

Telephone (home) _____ (cell) _____ (work) _____

Age _____ Birth Date _____ Social Security Number _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Other Spouse's Name _____ # of Children _____

Occupation _____ Employer _____ Avg. hours worked per week: _____

Email _____

Referred By _____ or How did you hear about us? _____

Medical Doctor _____ City _____

Emergency Contact _____ Phone # _____ Relationship _____

Previous Chiropractic Care? ☐ Yes ☐ No Doctor's Name _____ Date of last adjustment _____

Preferred Language: ☐ English ☐ Other_____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ White (Caucasian) ☐ Other ☐ I Decline to Answer

Ethnicity: ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

FINANCIAL INFORMATION

☐ I will be paying for the services myself (Cash patient) ☐ Health Insurance* ☐ Auto Insurance

☐ Worker's Compensation ☐ Other _____ ☐ If child, who is responsible for bill? _____

***PLEASE PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK. A COPY WILL BE PLACED IN YOUR FILE.**

PURPOSE OF THIS VISIT

Reason for this Visit: _____

When did your symptoms start? _____

How did you injure yourself? _____

Please select all that apply:

☐ Achy	☐ Radiating	☐ Stabbing	☐ Constant (75-100% of the day)
☐ Burning	☐ Sharp	☐ Stiffness	☐ Frequent (50-75% of the day)
☐ Dull	☐ Shooting	☐ Tingling	☐ Intermittent (25-50% of the day)
☐ Numbness	☐ Soreness	☐ Other	☐ Occasional (0-25% of the day)

Intensity of your symptoms: (No Pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)

The symptoms improve when I…_____

The symptoms worsen when I…_____

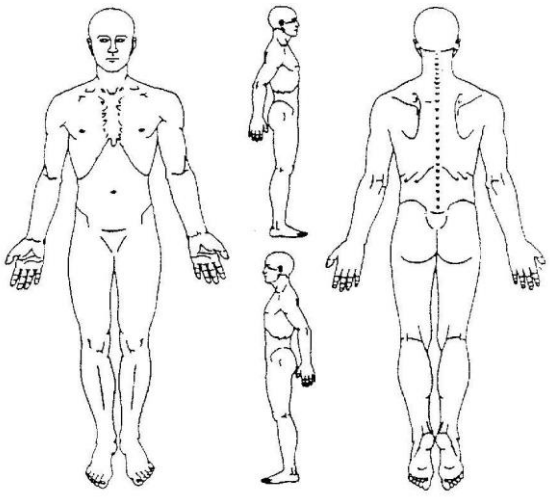
This prevents me from…_____

Home Remedies Used: ☐ Ice ☐ Heat ☐ Tylenol ☐ Ibuprofen ☐ Other _____

Who have you seen for your symptoms? ☐ No one ☐ Chiropractor ☐ Surgeon
☐ MD ☐ Physical Therapist ☐ Other

What treatments/tests were performed: ☐ X-ray ☐ MRI ☐ Other _____

Please indicate where you have pain or other symptoms:



Comments _____

_____

_____

HEALTH HISTORY

Have you ever experienced this problem before? ☐ Yes ☐No Please State: _____

Have you ever had any surgery? ☐ Yes ☐No Please State: _____

Have you ever had any car accidents? ☐ Yes ☐No Please State: _____

Sports injuries, falls, broken bones? ☐ Yes ☐No Please State: _____

Smoking Status: ☐ Every Day Smoker/# of Packs per Day: _____ ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Do you consume alcohol? ☐ Yes ☐ No # of Drinks per week: _____

Do you exercise? ☐ No ☐ Yes If yes, how many days per week do you exercise? ☐ 1-2 days ☐ 3-4 days ☐ 5+days

Women only: Are you pregnant? ☐ Yes ☐ No Number of weeks: _____ Anticipated Due Date: _____

Are you currently taking any medications? ☐ Yes ☐ No (Please include prescriptions & regularly used over the counter medications.)

Medication Name	Dosage & Frequency	Medication Name	Dosage & Frequency

Do you have any medication allergies? ☐ Yes ☐ No (If Yes, Please List below.)

Medication Name	Reaction	Onset Date	Additional Comments

Personal Health History: Please check all that you have or have had:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/ Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Excessive Menstruation
- ☐ Eye Pain/ Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart: Irregular Beat
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of Memory
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Migraine Headache
- ☐ Multiple Sclerosis
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of Breath
- ☐ Sinus Infection
- ☐ Sleep Problems/ Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Weight Loss
- ☐ Other (List): _____ _____

Family History: Please note any family history of the following conditions and include relationship of relative to you:

- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Headache _____
- ☐ High Blood Pressure _____
- ☐ Arthritis _____
- ☐ Epilepsy _____
- ☐ Heart Disease _____
- ☐ Stroke _____
- ☐ Spine or back disorder _____
- ☐ Multiple Sclerosis _____
- ☐ Psychological Problems _____
- ☐ Other _____

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor. The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care.

_____

Patient's Signature

SPENCER CHIROPRACTIC & WELLNESS CENTER

Name: _____ Date:

1025 5th Ave SE
Spencer, IA 51301
712-580-3294

Patient Health Information Consent Form

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

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or 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 obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. 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.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. 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 this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy office and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by the is office.
8. Our office reserves the right to make change to this notice and to make the new notice provisions effected for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purposed 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.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____ _____
Name of Patient (Please Print) Date

_____ _____
Signature Parent, Guardian, or Legal Representative

SPENCER CHIROPRACTIC & WELLNESS CENTER

INFORMED CONSENT FOR CHIROPRACTIC CARE

Lee Malmstrom, DC Leah Malmstrom, DC
Rex Jones, DC Elizabeth Kressin, DC

1025 5th Ave SE, Spencer, IA 51301

A patient, in coming to Spencer Chiropractic & Wellness Center P.C., gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures if he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The doctors provide a specialized, non-duplicating health care service. Our doctors are licensed in a special practice and are available to work with other types of providers in your health care regime.
I understand that if I am accepted as a patient by a physician at Spencer Chiropractic & Wellness Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____

Parent/Guardian Signature if patient is under 18_____

INSURANCE INFORMATION

Please check any and all insurance coverage that may be applicable in this case:

Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident □
Medical Savings Account & Flex Plans □ Other _____

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____