BLUESTONE CHIROPRACTIC

Confidential Patient Case History

Date _____

Name _____ Home Phone_____ Cell Phone_____

Address _____ City _____ State_____ Zip _____

Age ____ Birth Date _____ Sex M F Marital Status M S W D Number of Children _____ SS#_____

Employer _____ Occupation _____ e-mail _____

Work Address _____ Work Phone _____

Name of Spouse _____Spouse's Work Phone _____

In Case of Emergency, please notify _____ Phone _____

How did you hear about our office? Friend _____ □ Phonebook □ Employer □ Internet □ Other

Please list complaints and date the condition started, starting with your major complaint.

Complaints	Date Started
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

Is your condition getting worse? □ Yes □ No Is it Constant? □ Yes □ No Comes and Goes? □ Yes □ No
Have you seen other doctors for this condition? □ Yes □ No

Please list other doctors seen and approximate date seen (including primary care physician):

Doctor	Approximate Date Seen
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Have you experienced any serious accidents or falls within the □ Past year? □ 5 years? □ Over 5 years □ Never

If you have experienced an accident, what type was it? □ Auto □ Work □ Home □ Leisure □ Sports □ Other _____

Briefly Explain: _____

Are you presently taking any medication? □ Yes □ No Please List _____

List Surgical procedures you have had and an approximate date.

Procedure	Date
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Has any blood relative ever had:

	Who		Who
Cancer	_____	Stroke	_____
Diabetes	_____	Arteriosclerosis	_____
Heart Trouble	_____	Arthritis	_____
High Blood Pressure	_____	Spinal Curvature	_____

Check the following that you have had:

□ Alcoholism	□ Chorea	□ Gout	□ Multiple Sclerosis	□ Stroke
□ Anemia	□ Cold Sores	□ Heart Disease	□ Mumps	□ Tuberculosis
□ Appendicitis	□ Diabetes	□ Influenza	□ Pleurisy	□ Typhoid Fever
□ Arteriosclerosis	□ Diptheria	□ Lumbago	□ Pneumonia	□ Ulcers
□ Arthritis	□ Eczema	□ Measles	□ Polio	□ Whooping Cough
□ Asthma	□ Emphysema	□ Migraines	□ Rheumatic Fever	
□ Cancer	□ Epilepsy	□ Miscarriage	□ Scarlet Fever	

Check the following symptoms you have had within the past year:

General
- □ Allergy
- □ Chills
- □ Convulsions
- □ Dizziness
- □ Fainting
- □ Fatigue
- □ Fever
- □ Headache
- □ Loss of Sleep
- □ Loss of weight
- □ Depression
- □ Neuralgia
- □ Sweats
- □ Tremors

Cardiovascular
- □ Chest pain
- □ Angina
- □ ↑ blood pressure
- □ Low blood pressure
- □ Poor circulation
- □ Rapid Heart beat
- □ Slow heart beat
- □ Ankle swelling

Muscle & Joint
- □ Arthritis
- □ Bursitis
- □ Foot trouble
- □ Hernia
- □ Low back pain
- □ Lumbago
- □ Neck Pain
- □ Shoulder Pain

Pain or numbness in:
- □ Shoulders
- □ Arms
- □ Elbows
- □ Hands
- □ Hips
- □ Legs
- □ Knees
- □ Feet
- □ Tailbone

- □ Poor Posture
- □ Sciatica
- □ Spinal Curvature
- □ Swollen joints

Eyes, Ears, & Nose
- □ Asthma
- □ Colds
- □ Crossed Eyes
- □ Deafness
- □ Dental Decay
- □ Ear Ache
- □ Ear Discharge
- □ Ear Noises
- □ Enlarged glands
- □ Enlarged thyroid
- □ Eye pain
- □ Failing vision
- □ Far sightedness
- □ Gum trouble
- □ Hay fever
- □ Hoarseness
- □ Nasal obstruction
- □ Near sightedness
- □ Nosebleeds
- □ Sinus Infection
- □ Sore throat
- □ Tonsillitis

Respiratory
- □ Chest pain
- □ Chronic cough
- □ Difficulty breathing
- □ Spitting up blood
- □ Spitting up phlegm
- □ Wheezing

Gastro-intestinal
- □ Belching or gas
- □ Crohn's disease
- □ Colitis
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficult Digestion
- □ Gall Bladder trouble
- □ Hemorrhoids
- □ Jaundice
- □ Liver trouble
- □ Nausea
- □ Stomach pain
- □ Poor appetite
- □ Vomiting
- □ Rectal pain

Skin
- □ Bruise easily
- □ Dryness
- □ Hives or allergy
- □ Itching
- □ Rashes
- □ Varicose Veins

Genito-urinary
- □ Bed wetting
- □ Blood in urine
- □ Frequent urination
- □ Bladder control
- □ Kidney infection
- □ Painful urination
- □ Prostate trouble

Women Only
- □ Cramps
- □ Excessive flow
- □ Hot Flashes
- □ Irregular cycles
- □ Menopause
- □ Painful Flow
- □ Vaginal Discharge

	Yes	No
Have you ever been knocked unconscious?	□	□
Do you use a cane or other support?	□	□
Have you been treated for a spine or nerve disorder?	□	□
Have you ever had a fractured bone?	□	□
Have you been hospitalized for anything other than surgery?	□	□
Do you smoke?	□	□
Do you now take vitamins or minerals?	□	□

Habits:

	Heavy	Moderate	Light	None
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Appetite	□	□	□	□

Date of Last:

	< 6 months	6-18 months	>18 months	Never
Spinal Examination	□	□	□	□
Physical Examination	□	□	□	□
Blood test	□	□	□	□
Chest x-ray	□	□	□	□
Spinal x-ray	□	□	□	□
Dental x-ray	□	□	□	□
Urine test	□	□	□	□

Are you pregnant? □ Yes □ No
How many weeks? _____

Please check the type of care you desire so that we may be guided by your wishes when possible:

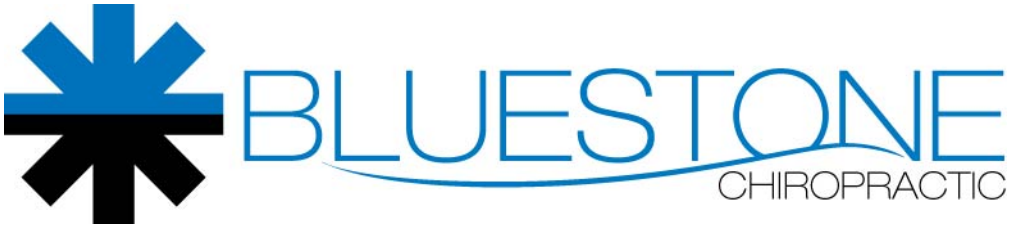
□ I prefer the doctor to select the type of care he feels is best for me □ Maximum improvement □ Temporary relief

Are you insured? □ Yes □ No Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office 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 doctor's office 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature _____ Date _____

Guardian's Signature _____ Date _____



INFORMED CONSENT

Chiropractic is a non-surgical, non-invasive procedure and has one of the safest records in health care. As with any health care specialty, we cannot promise a cure, but we will give you the best care possible and discuss any questions or concerns with you.

Patients may experience temporary symptoms such as an increase in soreness following a massage, manipulation or traction. In addition, physiotherapy such as ice, heat, ultrasound or electrical muscle stimulation may irritate the skin. There have been rare cases where adjustments may have aggravated a bulging or herniated disc or caused a rib fracture. On extremely rare occasions, adjustments to certain areas of the cervical spine have been related to a compromise of the vertebral artery and possible stroke symptomatology. The most recent studies (Journal of the CAA, Vol. 37, No 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature_____
Date_____

Parent/Legal Guardian Signature_____
Date_____

NOTICE OF PRIVACY PRACTICES

- We will use your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations.
- We have updated our electronic billing software to be HIPAA compliant.
- It is possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews.
- Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment.
- We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence.
- We may be required to disclose to Federal officials or military authorities, health information necessary to complete an investigation related to public health or national security.
- We will not disclose your health information other than with your written authorization.

YOU HAVE THE RIGHT :

- To request restriction on certain uses and disclosures for your health information.
- To request that we communicate with you in a certain way.
- To read, review and copy your health information, including your complete chart, x-rays and billing records.
- To ask us to update or modify your records if you believe your health information records are incorrect or incomplete.
- To ask us for a description of how and where your health information was used by our office for any reason other than treatment, payment or health operations.
- To obtain copies of this Notice of Privacy Practices.
- To express complaints to us or to the Secretary of Health & Human Services if you believe your privacy rights have been compromised.

Patient Acknowledgment

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much you acknowledging your receipt of our policy by signing, dating and returning this notice.

_____ _____

Patient Signature Date

South Scottsdale Chiropractic
2765 N Scottsdale Rd, #108
Scottsdale, AZ 85257

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

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

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____