Patient Name: _____ Date: _____

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Occupation_____

Employer_____

Emergency Contact and Phone Number:
_____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. Since the Motor Vehicle Collision, have you experienced any of the following:

A. Loss of Range of Motion: yes/no
   a. What body parts: _____
B. Visual Disturbance: yes/no □ blurring l/r □ floaters l/r □ vision loss l/r □ hypersensitivity l/r
   % of time: ___ % of time: ___ % of time: ___ % of time: ___

C. Dizziness: yes/no % of time: ____
D. Anxiety/Depression: yes/no % of time: ____
E. Difficulty Sleeping: yes/no

2. Past Health History:

A. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

B. Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies: _____

Patient Name: _____ Date: _____

3. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

A. Deaths in immediate family:

Cause of parents' or siblings' death Age at death

_____

_____

4. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle:

Hobbies: _____

Level of Exercise: _____

Alcohol Use: _____

Tobacco Use: _____

Drug Use: _____

Diet: _____

5. Medications:

Medication Reason for taking

_____

_____

_____

_____

Patient Name: _____ Date: _____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **oncological (cancer-related)** issues?
□ Fevers/chills/sweats/unexplained weight loss □ Abnormal bleeding/bruising
□ Current/past oncology disease _____

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **William Porath, D.C.** for services performed.

Patient or Guardian Signature _____
Date_____

Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one) If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom 2 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one) If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom 3 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one) If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____