COLUMBIA
CHIROPRACTIC CENTER Keeping Columbia Moving

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Patient Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of
Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20_____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

HIPPA CONSENT

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AUTHORIZATION

Consent for Treatment

Assignment & Release *- By signing below, I authorize Columbia Chiropractic Center to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Columbia Chiropractic Center and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my informed consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Name of Patient: _____ **Date:** _____

Signature of Patient/Legal Guardian: _____ **Date:** _____

Pregnancy Waiver

I hereby acknowledge that a doctor from Columbia Chiropractic Center has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated of my own volition that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused using this procedure.

Patient Signature: _____ **Date:** _____
Patient name: _____

Witness Signature: _____ **Date:** _____

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PATIENT APPLICATION FOR ADMISSION

PATIENT INFORMATION

Legal Name_____ Preferred Name _____ Address _____ City _____
State _____ Zip _____ Phone _____ Email _____
SSN# ___-___-_____ Date of Birth ____/____/_____ Age _____ ☐Male ☐Female **Marital Status**
☐Single ☐Married ☐Widowed ☐Divorced
Employer _____**Occupation** _____
Who is your family support system? *(Family, Children, Friend(s), etc.)*
_____
Emergency Contact
Name _____ Relationship _____ Phone _____
How did you hear about our office?
☐Columbia Chiropractic Center Website ☐Search Engine: _____
☐Community Event: _____ ☐Health Talk: _____ ☐Law Firm: _____ ☐Dr Referral: _____
Patient Referral - who can we thank for sharing the benefits of care with you?
_____
Are you receiving care from other health care professionals? ☐Yes ☐No
If yes, please name them and their specialty:
_____
Who is your family's primary care physician:
_____
Location: _____

Columbia Chiropractic Center believes that health care is a team effort. May we have your permission to update your medical doctor regarding your care at this office? ☐Yes ☐No

Please list any medications, herbs, supplements, homeopathies, or other remedies you are currently taking:
_____
_____
_____

Please list any surgeries you have had and the date:
_____
_____
_____

How often do you drink alcoholic beverages? _____
Do you smoke? ☐Yes ☐No How often? _____
Do you exercise? ☐Yes ☐No How often? _____ Type? _____

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FAMILY HISTORY

Check those involving family and include identification.
Please add type next to the checked selection

	Mother	Father	Siblings	Grandparent
Depression				
Diabetes				
Back Problems				
Cancer				
Heart Disease				
Liver Disease				
High Blood Pressure				
High Cholesterol				
Lung Problems				
Scoliosis				
Neck Problems				
Osteoporosis				
Seizures				
Osteoarthritis				
Rheumatoid Arthritis				

Please list any other family history not listed above:

_____

_____

MEDICAL HISTORY

Do you have any medical conditions listed below?

- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Back Problems
- ☐ Heart Disease
- ☐ Liver Disease
- ☐ High-Blood Pressure
- ☐ High Cholesterol
- ☐ Lung Problems
- ☐ Scoliosis
- ☐ Neck Problems
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis

If yes to cancer:

Type: _____ Stage: _____

Treatment Type: _____

If yes to diabetes:

Type: _____

Treatment Type: _____

Other and describe:

_____

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Do you have any allergies to foods/medications/nutrition's? Yes/No

If yes, please list and describe below:

_____

_____

_____

Have you ever had chiropractic care? ☐Yes ☐No

If yes, please tell us the doctor's name and when care occurred:

_____

Were you pleased with your care? ☐Yes ☐No

Do you know what **subluxation** is? ☐Yes ☐No

Do any of your friends or relatives see a chiropractor? ☐Yes ☐No

If yes, do they use chiropractic for:

☐Health maintenance/optimization ☐ Health problems ☐Both

Are you seeking care for:

☐Health maintenance/optimization ☐ Health problems ☐Both

Are you aware of the massive benefits of chiropractic care for children? ☐ Yes ☐ No

What would you like to gain from care?

_____

CHIROPRACTIC & DAILY ACTIVITIES

Does your condition limit your ability to *DRIVE*?

☐Unable to drive due to pain ☐Able to drive 60 minutes ☐30 minutes ☐10 minutes ☐No limitation

Does your condition limit your ability to *CARRY* objects?

☐Unable to carry any weight ☐Can carry heavy objects ☐Moderate objects ☐Light objects ☐No limitation

Does your condition limit your ability to *SLEEP*?

☐Unable to sleep ☐Loss of 3-5 hours ☐Loss of 2-3 hours ☐Loss of 1-2 hours ☐No limitation

Does your condition limit your ability to *STAND*?

☐Unable to stand ☐Able for <10 minutes ☐15 minutes ☐30 minutes ☐60 minutes ☐No limitation

Does your condition limit your ability to *SIT*?

☐Unable to sit ☐Able for 1 hour ☐Able for 2 hours ☐Able for 4 hours ☐Able for 8 hours ☐No limitation

Does your condition limit your ability to go from *SITTING TO STANDING*?

☐Unable without help ☐Able from highchair ☐Recliner ☐Medium chair ☐No limitation

Does your condition limit your ability to *WALK*?

☐Unable to walk ☐No more than 10 feet ☐100 feet ☐½ mile ☐1 mile ☐No limitation

Does your condition limit your ability to perform *HOUSEWORK*?

☐Unable to do housework ☐Able to do <10 minutes ☐15 min ☐30 min ☐60 min ☐No limitation

Does your condition limit your ability to *BEND*?

☐Unable to bend ☐Can bend 1⁄4 of the way ☐Can bend halfway ☐Can bend ¾ of the way ☐No limitation

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If we can help, what is your level of commitment to correcting your problem (s)?

LOW					MEDIUM				HIGH
1	2		3	4	5	6	7	8	9	10

What health condition brings you to our office:

_____

Indicate the current intensity of your complaint:

Mild *Severe*

1	2	3	4	5	6	7	8	9	10

Indicate the percentage of daytime it is present:

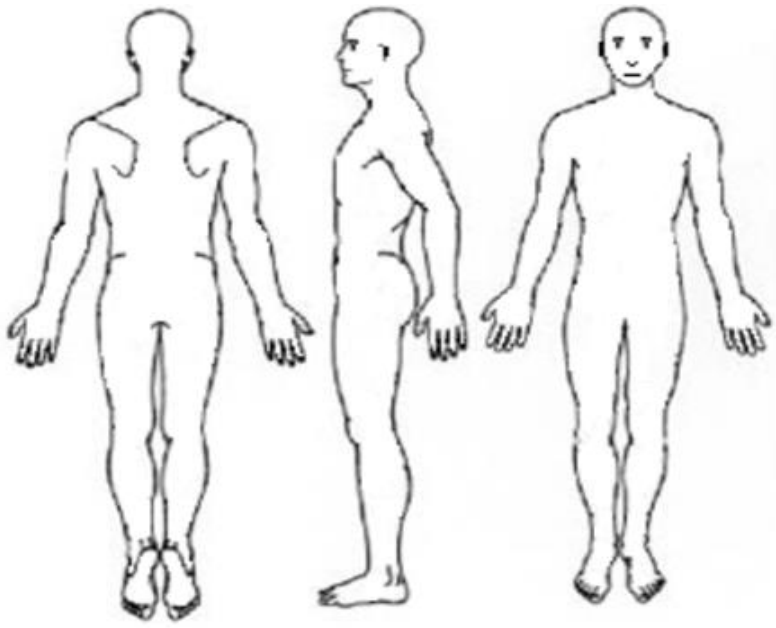
None *All Day*

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

How long have you been experiencing your main complaint?

_____

Has the intensity ever been at a level of 9 or 10? ☐Yes ☐No



Using the letters below, please show <u>where</u> you are experiencing all of your current complaints:

A=Ache **B**=Burning **ST**=Stabbing **C**=Cramping **N**=Numbness **P**=Pins and Needles **T**= Throbbing

What makes it feel better:

_____

What makes it feel worse:

_____

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Does this affect your work or other activities:

- ☐Decision making
- ☐ Unable to work.
- ☐Decreased productivity
- ☐ Poor attitude
- ☐Exhausted at the end of day
- ☐Other: _____

Does this affect your life:

- ☐Lose patience with spouse or children
- ☐Restricted household duties
- ☐Hinders ability to exercise/play sports
- ☐Hinders ability to participate in hobbies/recreation

I acknowledge that the above information is true and accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____

Complaints & Functional Assessment Pre-Treatment: ***(Providers only)***

Patient's subjective and objective data reviewed, and primary areas being considered for treatment are:

1. _____VAS (_____/10)
2. _____VAS (_____/10)
3. _____VAS (_____/10)

Goals & Desired Functional Improvement Post-Treatment:

1. _____
2. _____
3. _____