

North County Pain Relief Center
7157 N Lindbergh Blvd - Hazelwood MO 63042 - (314) 731- 4201
Dr. Adam Elsey, D.C.

Patient Name _____ Date _____

Confidential Patient Health Record

Personal Information

Title: Mr. Mrs. Ms.

Last: _____ First: _____ Middle: _____

Suffix: Jr. Sr. II III Birth Date: ___/___/___ Age: _____ Sex: Male / Female

Marital Status: Single Married Widowed Divorced Separated

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Ext _____

Home Phone: (_____) _____ - _____ Fax #: (_____) _____ - _____ Ext _____

Email Address: _____ Social Security # _____

Emergency Contact

Last: _____ First: _____ Middle: _____

Relationship: Spouse Relative Friend Other _____

Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Ext _____

Home Phone: (_____) _____ - _____

Employment Information

Business Name: _____

Phone: (_____) _____ - _____ Fax #: (_____) _____ - _____ Ext _____

Employer's Email Address: _____

Occupation/Job Title: _____ Job Description: _____

Patient Name _____ Date _____

Current Health Condition

Unwanted Condition (Why are you here today?) _____

When did this condition BEGIN? ____/____/____

Has it occurred before? Yes No When? _____

Is the condition: Auto Related Job Related Home Injury

Slip or Fall Lifting Slept Wrong Unknown Other

Explain: _____

Date of Accident: ____/____/____ Time of Accident: _____

Condition/Pain STARTED on what date: _____

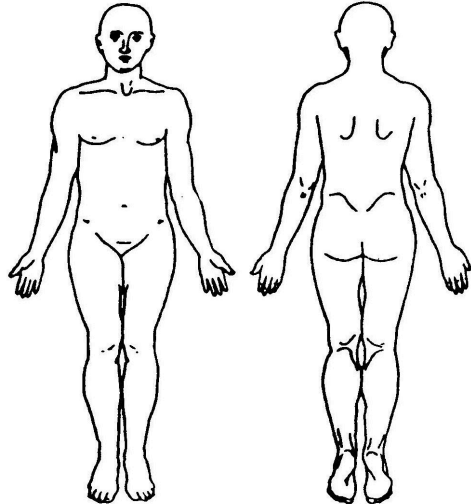
INDICATE YOUR PAIN LEVELS BELOW FOR EACH INJURED AREA

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

- 0 -1: NO PAIN- to just barely noticeable.
- 2 - 3: Pain is present, but you may have to stop and think about it to really tell it is there and not gone. You feel fairly comfortable.
- 4 - 5: You now notice your pain perhaps at rest or during activity. It may interfere with your activities.
- 6 - 7: Your pain is distracting you, you may be able to focus on something else rather than the pain for only short periods of time. You may be gritting your teeth or holding your breath to carry out activities.
- 8 -9: Your pain may be severe enough that it makes you stop in the middle of an activity, or not be able to complete it. It is difficult to think of anything else but your pain. You may be uncomfortable during rest or quiet times.
- 10: Your pain is now the worst you can imagine, though it is not necessary for you to be "crying" at this level

Use the letters below to indicate the TYPE and LOCATION of your sensations right now.

**Key: A = Ache B = Burning N = Numbness
P = Pins & Needles S = Stabbing**



REVIEW OF SYSTEMS - Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: I DENY having or have had any of the symptoms or problems listed below.

- chills fatigue night sweats weight loss
- daytime drowsiness fever weight gain

Eye/Vision: I DENY having or have had any of the symptoms or problems listed below.

- blindness change in vision field cuts photo phobia
- blurred vision double vision glaucoma tearing
- cataracts eye pain itching wear glasses/contacts

Ear, Nose & Throat: I DENY having or have had any of the symptoms or problems listed below.

- bleeding ear drainage hearing loss nosebleeds sore throat
- dentures ear pain history of head injury postnasal drip ringing in ears
- difficulty swallow fainting hoarseness runny nose TMJ problems
- discharge frequent sore throat loss of smell sinus infection headaches
- dizziness snoring nasal congestion

Respiration: I DENY having or have had any of the symptoms or problems listed below.

- asthma coughing up blood sputum production cough
- shortness of breath wheezing

Patient Name _____ Date _____

Cardiovascular: I DENY having or have had any of the symptoms or problems listed below.

- | | | |
|--|--|---|
| <input type="checkbox"/> angina (chest pain) | <input type="checkbox"/> varicose veins | <input type="checkbox"/> shortness of breath w/exertion |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> swelling of legs |
| <input type="checkbox"/> claudications (leg pain/ache) | <input type="checkbox"/> difficulty breathing lying down | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> palpitations | |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> wake up at night w/shortness breath | |

Gastrointestinal: I DENY having or have had any of the symptoms or problems listed below.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool caliber |
| <input type="checkbox"/> belching | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice | <input type="checkbox"/> abnormal stool color |
| <input type="checkbox"/> black - tarry stool | <input type="checkbox"/> heartburn | <input type="checkbox"/> nausea | <input type="checkbox"/> abnormal stool consistency |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> snoring | <input type="checkbox"/> nasal congestion | <input type="checkbox"/> vomiting |

Female: I DENY having or have had any of the symptoms or problems listed below.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> birth control | <input type="checkbox"/> burning urination | <input type="checkbox"/> vaginal bleeding | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> hormone therapy | <input type="checkbox"/> frequent urination | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> breast lumps/pain |
| <input type="checkbox"/> pregnancy | <input type="checkbox"/> urine retention | <input type="checkbox"/> cramps | |

Male: I DENY having or have had any of the symptoms or problems listed below.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> burning urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> prostate problems | <input type="checkbox"/> urine retention |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/dribbling | | |

Endocrine: I DENY having or have had any of the symptoms or problems listed below.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> cold intolerance | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> abnormal frequency of urination | |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> hair loss | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> goiter | <input type="checkbox"/> heat intolerance | <input type="checkbox"/> voice changes |

Skin: I DENY having or have had any of the symptoms or problems listed below.

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss | <input type="checkbox"/> itching | <input type="checkbox"/> skin lesion/ulcers |
| <input type="checkbox"/> changes in skin color | <input type="checkbox"/> hives | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities |
| <input type="checkbox"/> hair growth | <input type="checkbox"/> history of skin disorder | <input type="checkbox"/> rash | |

Nervous System: I DENY having or have had any of the symptoms or problems listed below.

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> limb weakness | <input type="checkbox"/> numbness | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremor |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> seizures | <input type="checkbox"/> stress | <input type="checkbox"/> unsteady gait |
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of memory | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes | <input type="checkbox"/> loss of balance |

Psychologic: I DENY having or have had any of the symptoms or problems listed below.

- | | | | | |
|---|--|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> anhedonia | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsion | <input type="checkbox"/> memory loss | <input type="checkbox"/> bi-polar disorder |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> confusion | <input type="checkbox"/> depression | <input type="checkbox"/> insomnia | <input type="checkbox"/> mood changes |
| <input type="checkbox"/> loss/change appetite | <input type="checkbox"/> loss of consciousness | | | |

Allergy: I DENY having or have had any of the symptoms or problems listed below.

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> anaphylaxis | <input type="checkbox"/> itching | <input type="checkbox"/> chronic nasal congestion | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> acute nasal congestion | <input type="checkbox"/> rash | |

Hematologic: I DENY having or have had any of the symptoms or problems listed below.

- | | | | |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> blood clotting | <input type="checkbox"/> bruising easily | <input type="checkbox"/> lymph node swelling |
| <input type="checkbox"/> bleeding | <input type="checkbox"/> blood transfusion | <input type="checkbox"/> fatigue | |

Patient Name _____ Date _____

PAST HEALTH HISTORY - Fill out carefully as these problems can affect your overall course of care.

Previous care for this SAME CONDITION I have not previously seen a doctor for this condition. OR FILL in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No If yes, when? ____/____/____

Dr.'s Name: _____ Type of treatment: _____

Was it beneficial in resolving condition? Yes No Explain: _____

Previous Chiropractic Care: I have not previously seen a chiropractor OR Fill in information BELOW

Dr.'s Name: _____ Location: _____ Date of last visit: _____

Current Medications: List ANY/ALL medications you are CURRENTLY TAKING. Please be specific

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illnesses: LIST all health conditions. CIRCLE ALL CURRENT conditions

- | | | | |
|--|--|------------------------------------|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> chicken pox | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> dermatitis | <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> allergies/hay fever | <input type="checkbox"/> depression | <input type="checkbox"/> HIV | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> measles | <input type="checkbox"/> spina bifida |
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear infections | <input type="checkbox"/> mumps | <input type="checkbox"/> other |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> fetal drug exposure | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> food allergies (list below) | <input type="checkbox"/> rash | |

Adult Illnesses: LIST all health conditions. CIRCLE ALL CURRENT conditions

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problem |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> depression | <input type="checkbox"/> influenza pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoid) | <input type="checkbox"/> past similar conditions |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> thyroid problem |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | |

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? yes no

Patient Name _____ Date _____

Surgery (ies): List all surgical procedures. Write the DATE of the procedure immediately afterward

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental surgery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsillectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | |

Injury (ies): List all injuries. Write the DATE of the procedure immediately afterward

- | | | |
|---|--|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> other |

Family History: Mark all that apply below. List specific conditions past or present after has/had

- | | | | | |
|----------------------|--|---|---|---|
| general family | <input type="checkbox"/> alive <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father | <input type="checkbox"/> alive <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother | <input type="checkbox"/> alive <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s) | <input type="checkbox"/> alive <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughters (s) | <input type="checkbox"/> alive <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother (s) | <input type="checkbox"/> alive <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister (s) | <input type="checkbox"/> alive <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

Insurance Information:

Who is responsible for your bill? YOU and (mark appropriate box (es)) Myself only Spouse
 Worker's Comp Auto Insurance Medicare Medicaid Other (be specific) _____
Personal Health Insurance Carrier: _____ Health ID Card #: _____
Policy Holder's Name: _____ Group #: _____
Policy Holders Date of Birth: ____/____/____ Primary Care Physician: _____

Workers Compensation Injury / Auto / Personal

Have you filed an injury report with your employer ? Yes No Date: ____/____/____ Time: _____
Carrier: _____ Policy # _____
Carriers Phone #: (_____) _____ - _____ Adjuster: _____
Claim #: _____ Attorney: _____

Patient Print Name: _____ Date: _____
Patient's Signature: _____ Date: _____

Patient: _____

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: <http://www.cms.hhs.gov/SecurityStandards/Downloads/securityproposedrule.pdf>.

1. The patient understands and agrees to allow this office to use their PHI for purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) name by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patient have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment & Informed Consent

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocation and sprains. Serious complications after manipulation of the cervical spine are estimated to be 1 in 4 million manipulations or fewer.

Initial _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third party payor.

Initial _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all the third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation

The patient accepts full financial responsibility for services by this practice.

Initial _____

Patient's Signature: _____ Date: _____