North County Pain Relief Center - Chiropractic Physician
7157 N Lindbergh Blvd - Hazelwood MO 63042 - (314) 731- 4201

Confidential Patient Health Record **Date** _____

Patient Information

Last: _____ First: _____ Middle: _____

Birth Date: ____/___/_____ Age:_____ Sex: [ ] Male [ ] Female Social Security # _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Second Phone: (_____) _____-_____

Email Address:_____

Legal Guardian Information - if patient is a minor (under 18)

First Name: _____ Last: _____ Relationship: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Second Phone: (_____) _____-_____

Email Address:_____

Emergency Contact

Last: _____ First: _____ Middle: _____

Relationship: [ ] Spouse [ ] Relative [ ] Friend [ ] Other _____

Best Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Ext_____

Employment Information

Business Name:_____

Describe Job Activities: _____

BEFORE YOUR INJURY, were you experiencing any of the following symptoms/problems?

[ ] back or neck pain [ ] headaches [ ] tingling in arm/hand [ ] tingling in leg/foot [ ] pain in arm or leg

Have you seen a doctor for any of the previous listed health problems? [ ] No [ ] Yes When?_____

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

*Have you **PREVIOUSLY** been treated for injuries due to an auto collision?* [ ] No [ ] Yes When?_____

Adult Illnesses: CHECK all health conditions. CIRCLE IF IT IS CURRENT

[ ] arthritis	[ ] heart disease	[ ] lung problems	[ ] Parkinson's disease
[ ] cancer	[ ] HIV	[ ] lupus	[ ] seizures
[ ] diabetes	[ ] high blood pressure	[ ] multiple sclerosis	[ ] strokes
[ ] fibromyalgia	[ ] liver disease	[ ] Other _____	_____

Patient Name _____ Date _____

Current Medications: List all medications you are currently taking.

Medication	For What Condition?	Medication	For What Condition?

Surgery (ies): List all surgical procedures.

Surgery	**Date**	**Surgery**	**Date**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Injury (ies): Mark the injuries you have had **BEFORE** this one.

[ ] back injury
[ ] broken bones
[ ] disability (ies)
[ ] fall (severe)
[ ] head injury
[ ] joint injury
[ ] motor vehicle accident
[ ] sports injury
[ ] work accident

Your Auto Insurance OR for the vehicle you were in

Date Of Accident: ____/____/____ Time: _____ Where did accident happen? [ ] Missouri [ ] Illinois [ ] Other _____

Did the police come? [ ] No [ ] Yes Did you report the accident/injury to your insurance company? [ ] No [ ] Yes

Name of Policy Holder: _____

Insurance Company: _____ Policy # _____

Insurance Phone #: (_____) _____ - _____ Adjuster: _____

Medical Claim #: _____ Attorney: _____

Person Who Hit You - Insurance

Person's Name:_____

Insurance Company: _____ Policy # _____

Insurance Phone #: (_____) _____ - _____ Adjuster: _____

Medical Claim #: _____ Attorney: _____

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Signature of parent or legal guardian if patient is under 18 years old.

Guardian Print Name: _____ Date: _____

Guardian's Signature: _____ Date: _____

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ph: 314.731.4201, fax: 314.731.4204

Patient: _____ Age: _____

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 (HIPPA) is available here: http;//ww.cms.hhs.gove/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) named by the patient for the purpose of payment. This includes the named attorney of record representing you. 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. A patient has 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: Patient _____ OR Parent or Legal Guardian _____

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: Patient _____ OR Parent or Legal Guardian _____

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: Patient _____ OR Parent or Legal Guardian _____

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. This includes release of medical & financial information to the patient's attorney.

Initial: Patient _____ OR Parent or Legal Guardian _____

Financial Obligation

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

Initial: Patient _____ OR Parent or Legal Guardian _____

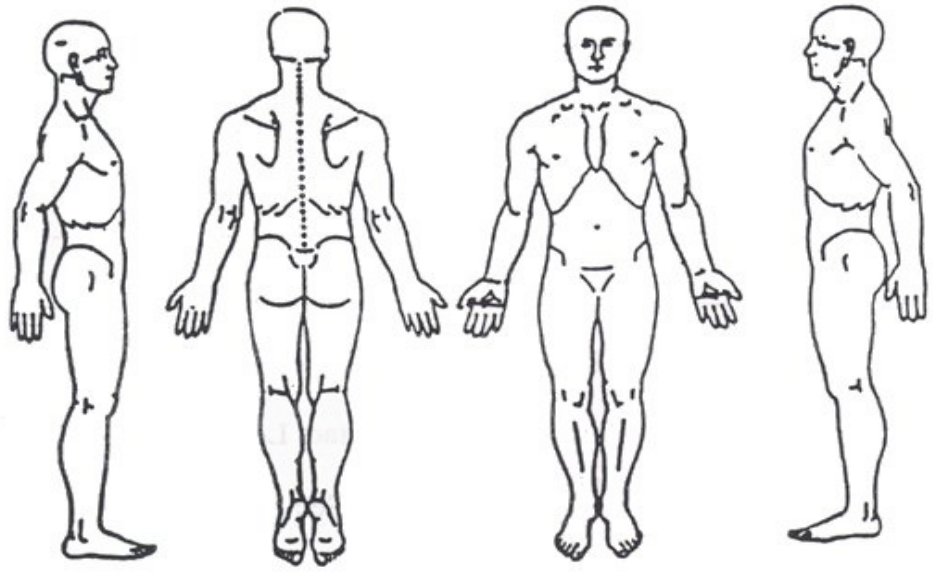
Patient's Signature: _____ Date: _____

Parent or Legal Guardian: _____ Date: _____

Patient Name_____ **Today's Date** _____/_____/_____

INJURY HISTORY **Date of Injury** _____/_____/_____ **Time of Injury**_____

Please mark the area of your pain or discomfort:



1. Is your condition currently... [ ] worsening [ ] improving [ ] unchanged?
2. Is your condition worse in the: [ ] Morning [ ] Afternoon [ ] Night [ ] With Activity

Circle any of the following you have experienced since your injury

Mood swings	Depression	Sensitive to sound	Dizziness
Confusion	Concentration Difficulties	Nausea	Balance problems
Ringing in the ears	Sensitive to light	Vomiting	Blurred Vision

Patient Name _____ Date _____

Please **use the following scale** to rate the intensity of **each** area injured from 1-10.

0 -1: NO PAIN- to just barely noticeable
2 - 3: MILD - Pain is present but does not limit your activities
4 - 5: MODERATE – You can do most activities with rest periods
6 - 7: SEVERE – **Unable to do SOME** activities because of pain
8 -9: EXTREME- **Unable to do MOST** activities because of pain
10: DISABLING – **Unable to do ANY** activities: including putting on clothes, bathing, cooking, driving, almost any movement.

Example

Circle Where YouHurt	How much of the day do you hurt? Occasional On and off Most of day All day	Intensity 1-10	Sharp	Dull	Aching	Throbbing	Shooting	Pins & Needles		
right side of neck, more on back of neck	***Most of day***	***6***	***x***			***x***	***x***			
Headache										
Neck										
Upper Back										
Low Back										
Shoulder Joint										
Elbow										
Wrist										
Hip										
Knee										
Ankle										
Foot										
Other:_____										
Other:_____										

Patient Name:_____

The next form is a request for medical records. If you have sought medical care of any kind for your injury, we need your permission to obtain a copy of those medical records.

Please sign the next form but leave the Doctor/Hospital information blank.

List below the urgent care, hospital(s) and/or doctor(s) that you have seen.

Urgent Care: _____ **Were X-rays taken? Y N**

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **When did you go?:**_____

Hospital: _____ **Were X-rays taken? Y N**

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **When did you go?:**_____

Doctor: _____ **Were X-rays taken? Y N**

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **When did you go?:**_____

Doctor: _____ **Were X-rays taken? Y N**

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **When did you go?:**_____

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(314) 731-4201 Fax (314) 731-4204

REQUEST FOR MEDICAL RECORDS

Date:_____

REQUESTING FROM:

_____ **RECORDS FAX:** _____
Doctor or Hospital Name

_____ **RADIOLOGY FAX:** _____
Address

_____
City, State, Zip

PATIENT INFORMATION

_____
Patient Name **Age**

_____
SS#

_____
Date Of Birth

Please send imaging films or disc and medical records from _____ **to the present.**

I authorize the release of my imaging films or disc and medical records to be sent to the requestor:

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This request is valid for 180 days past the date of signature seen below.

_____
Patient Signature **Date**

_____
Parent or Legal Guardian Signature **Relationship** **Date**

_____
Parent or Legal Guardian Print Name