



CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can serve you better. Please fill in as much information as possible, even if it does not apply to your current medical complaints. If you need any help filling this form out, we would be happy to assist you.

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone # _____ Cell Phone _____

Email: _____

Date of Birth ____/____/____ Age: _____ Marital Status: M S D W

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone#: _____

Spouse/Partner's Name _____

Who referred you to this office/how did you hear about us? _____

Is this visit due to an Auto or Work related injury? Yes / No

Is Medicare your primary insurance? Yes / No

For Women: Are you pregnant? Due Date: _____

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement or settlement.

Patient Signature: _____ Date: _____

Parent or Guardian: _____

Parent or Guardian Signature: _____ Date: _____

Current Primary Complaint

Please provide as much information as possible as this will allow us to properly treat your condition.

1. What primary complaint are you here for? _____

2. When did it begin? _____
3. Did it start suddenly, gradually or develop over time? _____
4. What caused it? _____
5. Describe the quality of the pain. (ie. Sharp, dull, aching, throbbing, etc.) _____
6. Is it constant, frequent, intermittent or occasional? _____
7. What makes it worse? (ie. Bending, lifting, standing, sleeping, sitting) _____

8. What makes it feel better? (i.e. Ice, heat, rest, medication) _____

9. Try to rate your pain on average between 0 and 10. 1 2 3 4 5 6 7 8 9 10
10. Does the pain radiate? If yes, where? _____
11. Do you experience any numbness or tingling? If yes, where? _____
12. Does it change throughout the day? _____
13. Does it interrupt your sleep? If yes, how often per night? _____
14. Have you taken any over-the-counter meds for it? What? _____
15. Have you taken any prescription medication for this pain? _____
16. Have you seen any other doctors or therapists for this complaint? _____

16. What have you tried that has not helped your complaint? _____
17. Do you have any secondary complaints?

Patient Name: _____ Date: _____

Medical History

Please circle anything **YOU** have or have had in the past:

- | | | | |
|--------------------|-----------------|----------------------|---------------------|
| Anemia | Arrhythmia | Arthritis | Asthma |
| Back Pain | Sciatica | Broken Bones | Cancer |
| Diabetes | Eating Disorder | Emphysema | Epilepsy |
| Gall Bladder Issue | Glaucoma | Gout | Headaches |
| Heart Disease | Heart Murmur | Heel Spurs | High Blood Pressure |
| Kidney Stones | Liver Disease | Lung Disease | Mental Disorder |
| Neuropathy | Osteopenia | Osteoporosis | Paralysis |
| Pneumonia | Tendonitis | Dislocations | Prostate Problems |
| Reflux/Ulcers | Rheumatic Fever | Rheumatoid Arthritis | Seizures/Epilepsy |
| Sickle Cell Anemia | Stroke | Thyroid Disease | STDs |
| Concussions | GI Problems | Numbness | Sinus Trouble |
| Allergies | Weakness | Bleeding Disorder | Depression/Anxiety |

Other: _____

Surgical History

Please list any surgeries and their approximate dates.

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Social History

Do you:

Smoke Y / N Amount per day? _____ Marijuana/Cigarettes?

Alcohol Y / N Drinks per week on average? _____

Exercise Y / N How often per week? _____

Work at Desk/Computer Y / N Work Standing Y / N

Medication/Supplements

Do you take any prescription medication? _____

Do you take any vitamins or supplements? _____

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 Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office 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, to pay your health care bills, to support the operation 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 protected health 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 use or 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 fundraising activities, and conducting 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 include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and 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.

Your Rights

Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____



Hochman Family Chiropractic

"Where our family heals your family"

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Informed Consent for Examination and Treatment

I hereby consent to the performance of examination and treatment on me, _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period _____

Patient's Name (Print)

Patient's Signature

Date

Witness