Patient Health History

Today's Date_____

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Mailing Address _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**E-Mail** _____

Date of Birth_____**Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ Caucasian ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑Other_____❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language _____ ❑ I choose not to specify

Referred to this Office by: ❑ Friend/Family Member – Name?_____

❑ Yellow Pages ❑ Mail ❑ Clinic Location❑ Other_____

Verification Question *(choose only **one** question by checking the box, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question(Must be at least 6 characters):_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including dosage & <u>DATE FIRST PRESCRIBED</u> if known.
If there are no current medications, check here: ❑

1) _____ **2)** _____

3) _____ **4)** _____

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **2)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

MEDICAL/FAMILY HISTORY **S** = Self **M** = Mother **F** = Father

S	M	F		S	M	F		S	M	F		S	M	F	
❑	❑	❑	Cancer Type_____	❑	❑	❑	Gastrointestinal Disorder Type_____	❑	❑	❑	Diabetes Type_____	❑	❑	❑	Kidney Disease Type_____
❑	❑	❑	COPD	❑	❑	❑	Emphysema	❑	❑	❑	Pneumonia	❑	❑	❑	Influenza
❑	❑	❑	Asthma	❑	❑	❑	Chronic Bronchitis	❑	❑	❑	Pulmonary Embolism	❑	❑	❑	Clotting Disorder
❑	❑	❑	Dementia	❑	❑	❑	Alzheimer's	❑	❑	❑	Angina	❑	❑	❑	Heart Attack
❑	❑	❑	Heart Disease	❑	❑	❑	Coronary Artery Disease	❑	❑	❑	High Cholesterol	❑	❑	❑	Hypertension
❑	❑	❑	Osteoporosis	❑	❑	❑	Septicemia	❑	❑	❑	Stroke/Brain Attack	❑	❑	❑	Bipolar Disorder
❑	❑	❑	Anxiety	❑	❑	❑	ADDH	❑	❑	❑	Autism	❑	❑	❑	Dementia
❑	❑	❑	PTSD	❑	❑	❑	OCD	❑	❑	❑	Schizophrenia	❑	❑	❑	Depression
❑	❑	❑	Personality Disorder	❑	❑	❑	Panic Disorder	❑	❑	❑	Eating Disorder				

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_____ Date of Last Physical Exam_____

SURGICAL HISTORY

_____Date:_____

_____Date:_____

_____Date:_____

Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No

ACCIDENT HISTORY:

❑Job ❑Auto ❑Other 1._____Date:_____

❑Job ❑Auto ❑Other 2._____Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your Symptoms (1-10, with 1 being the least serious)

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

HOW AND DATE IT OCCURRED?_____

_____

SYMPTOMS HAVE PERSISTED FOR #___HOUR(S) ____DAY(S) __WEEK(S) ____MONTH(S) ___YEAR(S)

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

ARE YOU PREGNANT ❑NO ❑YES, DATE OF LAST MENSTRUAL PERIOD_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑SITTING	❑STANDING	❑WALKING	❑BENDING	❑STOOPING	❑LIFTING
❑SLEEPING	❑SNEEZING	❑COUGHING	❑STRAINING	❑REACHING	❑TWISTING
❑LOOKING UP	❑LOOKING DOWN	❑MOVEMENT	❑REST	❑LYING SUPINE	❑DRIVING
❑TYPING	❑SCOOPING	❑HOUSE CHORES	❑EXERCISE	❑LYING PRONE	❑STAIR STEPPING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:

❑SITTING	❑STANDING	❑LYING	❑KNEES BENT UP	❑SUPPORT
❑NO MOVEMNT	❑MOVEMENT	❑HEAT	❑ICE	❑ANALGESIC TOPICAL
❑IBUPROFEN	❑MEDICATION	❑REST	❑STRETCHING/EXERCISE	❑ADJUSTMENT

HEIGHT:_____inches **WEIGHT:**_____pounds **BP:**_____/_____

CONSENT TO TREAT

Dr. Rohm will use his hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as “Spinal Manipulation” or “Spinal Adjustment.” As the joints in your spine are moved, you may experience a “pop” as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner’s Syndrome (also known as oculosympathethetic palsy), costovertebral stains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

Dr. Rohm is aware of these complications and in order to minimize their occurrence he will take precautions. These precautions include, but are not limited to Dr. Rohm taking a detailed clinical history of you and examining you for any defect which would cause a complication.

If you are pregnant, you should tell Dr. Rohm when he discusses your clinical history with you.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of policies and procedures concerning the privacy of your PHI we encourage you to go to the HHS web site at www.hhs.gov/ocr/privacy/hipaa/understanding/index.html.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The Patient has the right to examine and obtain a copy of his or her own 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. Our office is not obligated to agree to those restrictions.
3. A patient’s written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

Printed Name	Date
Signature	Signature of Parent or Guardian (if a minor)
Witness Signature	Date