

Personal Information

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Best Phone Number: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

(May we add you to the All About You email newsletter?)  
yes no

Sex:  M  F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Single Married Widowed Separated Divorced

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Emergency Notification Info

Name and relation to you: \_\_\_\_\_

Phone Number to reach them at: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Insurance

If you would like a receipt to submit to your insurance carrier for reimbursement, please ask for it and I will be happy to provide it for you.

Thank you

Your **Social Security Number** is not being asked for on this form. This is intended as a protection against identity theft. If at some future date it is needed, I will ask for it.

Thank you

Cancellation Policy

I ask that you give 24 hours notice if you need to cancel an appointment. If this becomes a repeated problem, I reserve the right to charge a \$20 fee for appointments not canceled 24 hours in advance. Hopefully this will never be an issue.

Is your condition due to an accident?  Yes  No

Date of accident: \_\_\_\_\_

Type of accident: Home Work Auto

Other \_\_\_\_\_

To whom have you made a report of your accident?

Employer Attorney Auto Insurance

Workers Compensation

Financial Agreement

I understand that all services can be paid for with cash or personal check. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the \$20 returned check charge in the event that my check is returned.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND  
HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

### **What your Record Contains:**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. Each time you are here, a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care and treatment. We need this record to provide you with quality care. This notice will tell you about the ways we may use and share medical information about you. It will also describe your rights, and our responsibility to maintain the privacy of your health information.

### **Use and Disclosure of your Medical Information:**

We may use your protected medical information for treatment. We may disclose information to your primary doctor, your referring doctor, and other healthcare providers involved in your treatment, directly or indirectly.

We may use your protected medical information for payment. We may disclose your information to obtain reimbursement for services from your insurance companies. We may disclose your information to your insurance company to obtain precertification for a procedure. We may use your protected medical information for healthcare operations and research purposes, such as quality assessment and improvement activities, for evaluating employee performance or training programs- without individually identifiable information (your name, SSN, birth date, etc. will be removed).

Certain disclosures may be made without your written authorization. Such disclosures are: communication with family member or other person involved in your care, notification of family member or other person responsible for your care, for public health and safety, in legal proceedings, for law enforcement - whenever we are required by law to disclose personal health information.

Any other uses and disclosures will be made only with your written authorization. You may revoke an authorization at any time in writing. Parents are the representatives of unemancipated minors.

### **Your Individual Rights:**

Although your health records are the physical property of your healthcare provider, you have rights, which you can exercise by presenting a written request to our office.

You have the right to request restrictions on certain uses and disclosures of protected medical information. We are, however, not required to agree to a requested restriction.

You have the right to request confidential communication of protected medical information by alternative means or at alternative locations.

You have the right to a copy of your protected medical information.

You have the right to amend your protected medical information, unless we did not create the record or if the record is accurate and complete.

You have the right to revoke your authorization to use or disclose medical information except to the extent that action has already been taken.

You have the right to obtain a paper copy of this notice upon request.

### **Our Responsibility:**

Under the provisions of Federal Law (HIPAA) we are mandated to maintain the privacy of your protected medical information, provide you with this Notice of Privacy Practices, and abide by the terms of this notice.

If you have questions about this notice, or if you feel that your privacy rights have been violated, you have the right to file a written complaint with this office. You may also submit a written complaint with the U.S. Dept. of Health & Human Services, Office of Civil Rights, 200 Independence Ave. SW, Washington, DC 20201. Toll Free: 1-877-696-6775.

By signing a copy of this Notice, you will certify that you have received and reviewed this notice and that all your questions have been answered to your satisfaction in language that you can understand.

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Print Name of Patient

Signature of Patient or Representative

Date

## First Visit Information

**Chief Complaint:** What led you to seek treatment today? \_\_\_\_\_

**Location:** Please identify the area(s) of complaint \_\_\_\_\_

**Onset:** When did this begin? \_\_\_\_\_

Has it gotten better, worse or remained unchanged? \_\_\_\_\_

Does it interfere with your: sleep, work, daily routine, recreation? \_\_\_\_\_

**Mechanism:** How did it happen? \_\_\_\_\_

**Quality:** What words would you use to describe your symptoms? For example: Dull, Achy, Sharp, Burning, etc... \_\_\_\_\_

**Radiation:** Do you experience your symptoms anywhere else in your body? For example: into your arms, legs, or into your head, etc... \_\_\_\_\_

**Frequency:** How often do you experience symptoms?

Constant (76-100%)    Frequent (51-75%)    Occasional (26-50%)    Intermittent (25% or less)

**Severity:** Rate your current pain on a scale from 0 (no pain) to 10 (worst pain) \_\_\_\_\_

**Temporal Factors:** Do your symptoms change in quality and/or severity throughout the day? \_\_\_\_\_

**Provocative:** What aggravates your symptoms? \_\_\_\_\_

**Palliative:** What makes you feel better? (ex: heat, cold, stretching, body position, etc...) \_\_\_\_\_

**Sleep:** How many hours do you sleep? \_\_\_\_\_ When you wake up do you feel rested? \_\_\_\_\_

**Associated Signs/Symptoms:** Are you experiencing any of the following?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Numbness and Tingling   | <input type="checkbox"/> Constant Pain                 | <input type="checkbox"/> Shortness of Breath/Difficulty Breathing |
| <input type="checkbox"/> Sudden Severe Headache  | <input type="checkbox"/> Sudden Vision Changes         | <input type="checkbox"/> Dizziness and/or Loss of Coordination    |
| <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Nagging Cough or Hoarseness   | <input type="checkbox"/> Loss of Bowel or Bladder Function        |
| <input type="checkbox"/> Night Sweats            | <input type="checkbox"/> Unusual Bleeding or Discharge | <input type="checkbox"/> None of the Above                        |

**Other HCP:** Have you seen any other Health Care Providers for this condition? \_\_\_\_\_

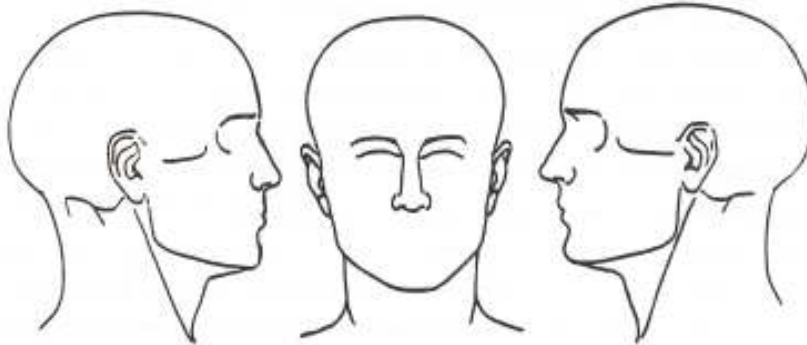
**XRays/Labs:** \_\_\_\_\_

**Patient Initials:** \_\_\_\_\_

# Pain Diagram

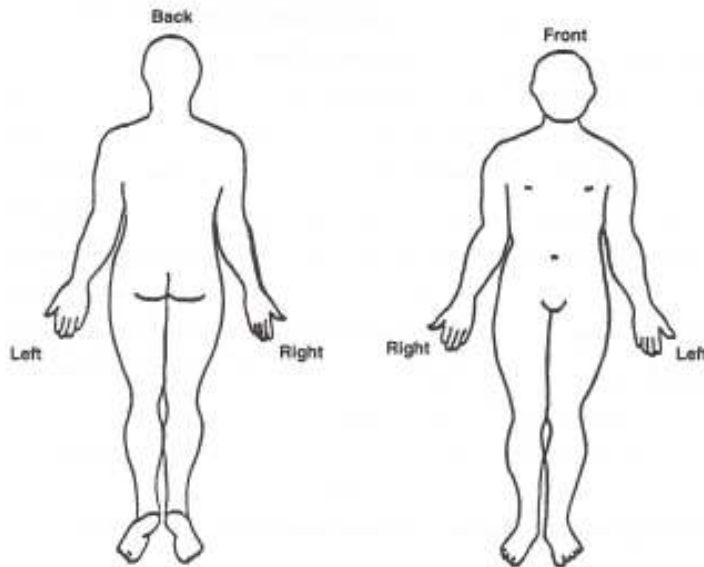
Please draw the location of your pain on the body outlines using the symbols given to indicate the type of pain. Mark the severity of pain that you are feeling right now on the lines below the diagrams.

Ache ^^^^^^ ^^^^	Burning =====	Numbness oooooo oooo	Pins and Needles ..... .....	Stabbing //////// ////	Other xxxxxx xxx
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No Pain |-----| Worst Pain Possible

Please make a slash through this line as to the level of your pain.



No Pain |-----| Worst Pain Possible

Please make a slash through this line as to the level of your pain.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

## Habits

Do you smoke? Yes No  
\_\_\_\_\_ packs per day  
\_\_\_\_\_ how many years?  
\_\_\_\_\_ interested in stopping?

Do you drink alcohol? Yes No  
\_\_\_\_\_ drinks per week

Caffeine? Yes No  
\_\_\_\_\_ drinks per week

Do you drink water? Yes No  
\_\_\_\_\_ drinks per day

In your daily diet, please rate the following:  
Salt intake: high low normal not sure  
Fat intake: high low normal not sure  
Starch intake: high low normal not sure

If you follow any diet regimes/restrictions, please describe: \_\_\_\_\_

What is your exercise routine?  
\_\_\_\_\_

Rate your: (0=low, 10=high)  
Stress level  
0 1 2 3 4 5 6 7 8 9 10

Energy level  
0 1 2 3 4 5 6 7 8 9 10

Do you fall asleep easily? Yes No

Do you wake during the night Yes No

How many times? \_\_\_\_\_

Do you easily fall back asleep? Yes No

Do you become drowsy /low energy during the day?

Yes No

How many hours do you sleep per night? \_\_\_\_\_

## Family History

Please note any family history of illness:

Who is your primary care physician? \_\_\_\_\_

What is your short term wellness goal (between this visit and a month)? \_\_\_\_\_

What is your long term wellness goal? \_\_\_\_\_

### Please list your current:

Medications:

Herbs /Supplements /Homeopathics:

Environmental /Food /Drug Allergies:

## Past Medical History

CIRCLE "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Anemia/ Bruise easy	YES	NO	High Cholesterol	YES	NO	Tonsillitis	YES	NO
Allergy Shots	YES	NO	Hospitalizations	YES	NO	Tremor /Hand Shaking	YES	NO
Arthritis	YES	NO	Indigestion /Heartburn	YES	NO	Tuberculosis	YES	NO
Asthma/ Wheeze	YES	NO	Infection - Freq	YES	NO	Tumors, Growths	YES	NO
Bleeding Disorder	YES	NO	Kidney Disease	YES	NO	Ulcers	YES	NO
Breast Lump	YES	NO	Kidney Stones	YES	NO	Urinary Infection -Freq	YES	NO
Bronchitis	YES	NO	Liver Disease	YES	NO	Vaginal Infections -Freq	YES	NO
Broken Bones	YES	NO	Loss of Appetite	YES	NO	Varicose Veins	YES	NO
Cancer	YES	NO	Migraine Headache	YES	NO	Other_____		
Cataracts	YES	NO	Miscarriage	YES	NO	Other_____		
Chronic Fatigue	YES	NO	Moodiness -Excessive	YES	NO			
Chemical Dependency	YES	NO	Muscle Weakness	YES	NO			
Constipation - Freq	YES	NO	Nervous /Depression	YES	NO	<b>FEMALES</b>		
Diabetes	YES	NO	Osteoporosis	YES	NO	Are pregnant?	YES	NO
Diarrhea - Freq	YES	NO	Pacemaker	YES	NO	Are you trying to become pregnant?		
Emphysema	YES	NO	Phobias	YES	NO		YES	NO
Ear Infections	YES	NO	Pinched Nerve	YES	NO	Is our menstrual flow:		
Epilepsy /Seizures	YES	NO	Pneumonia	YES	NO	Regular Irregular Stopped		
Gall Bladder Problems	YES	NO	Polio	YES	NO	Do you have:		
GERD	YES	NO	Prostate Problems	YES	NO	Pain Cramps Clotting Hot flashes		
Glaucoma	YES	NO	Psoriasis /Eczema	YES	NO	____Days of flow ____Length of Cycle		
Goiter	YES	NO	Rashes /Hives	YES	NO	The first day of your most recent period was what date? _____		
Gout	YES	NO	Recent Weight Loss	YES	NO	Please list any birth control methods you are using: _____		
Heart Disease	YES	NO	Rheumatoid Arthritis	YES	NO			
Headaches - Freq	YES	NO	Rheumatic Fever	YES	NO			
Head Injury	YES	NO	Scarlet Fever	YES	NO			
Hepatitis /Jaundice	YES	NO	Stroke	YES	NO			
Herniated Disc	YES	NO	Surgery	YES	NO			
Hernia	YES	NO	Swollen Ankles	YES	NO			
High Blood Pressure	YES	NO	Thyroid Problems	YES	NO			