CONFIDENTIAL PATIENT HEALTH RECORD --- MERIDIAN CHIROPRACTIC Date: _____

PERSONAL HISTORY

Name: _____ Birth Date: _____ Age: _____

Address: _____ Sex: Male / Female

City: _____ State: _____ Zip: _____ Home Phone: _____

Social Security #: _____ Cell Phone: _____

Driver's License #: _____ E-mail Address: _____

Business Employer: _____ Fax #: _____

Occupation: _____ Business Phone: _____

Name of Spouse: _____ Spouse's Employer: _____

Type of Work: _____ Names & Ages of Children: _____

Referred To This Office By: _____ _____

Name & Number of Emergency Contact: _____ Relationship: _____

Who is responsible for your bill? You and ☐Spouse ☐Worker's Comp ☐Auto Insurance ☐Medicare ☐Medicaid

Personal Health Insurance Carrier: _____ Health Card ID #: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: _____ Insured Person's Social Security #: _____

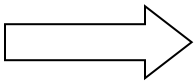
CURRENT HEALTH CONDITION

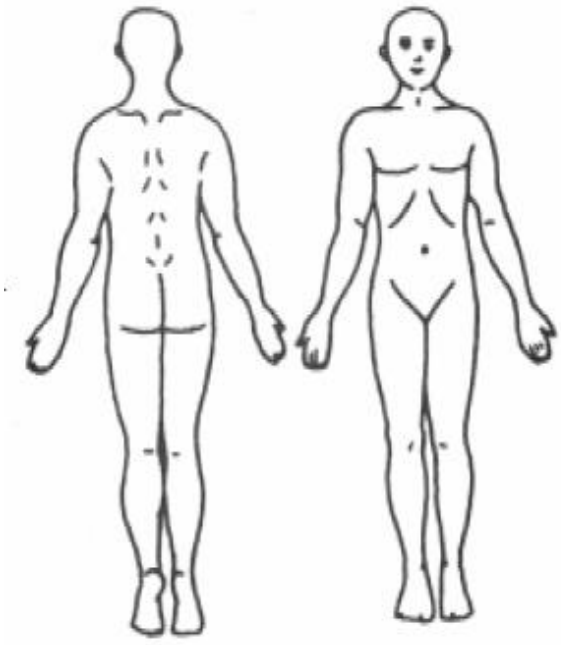
Chief Complain (why you are here today): _____

_____

_____

<u>*PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT*</u>





When did this condition begin? _____

Has it ever occurred before? ☐ Yes ☐ No

Is condition: ☐Auto related ☐Work related ☐Other ☐No injury

Explain: _____

Date of Accident: _____ Time of Accident:_____

On a scale of 1 to 10, rate your pain (10 = worst):_____

Complaint / Pain Onset Date: _____

If work, have you filed an injury report with your employer?

☐Yes ☐ No Claim #: _____

Patient Name: _____ Date: _____

IMPORTANT: Please check (x) all present symptoms.

HEAD:
___ Headache
- ___ Sinus (allergy)
- ___ Entire head
- ___ Back of head
- ___ Forehead
- ___ Temples
- ___ Migraine

___ Head feel heavy
___ Loss of memory
___ Light-headed
___ Fainting
___ Light bothers eyes
___ Blurred vision
___ Double vision
___ Loss of vision
___ Loss of balance
___ Loss of taste
___ Loss of hearing
___ Dizziness
___ Pain in ears
___ Ringing in ears

NECK:
___ Pain in neck
___ Neck pain with movement
- ___ Forward
- ___ Backward
- ___ Turning (L) (R)
- ___ Bending (L) (R)

___ Pinched nerve in neck
___ Neck feels out of place
___ Muscle spasms in neck
___ Grinding sounds in neck
___ Popping sounds in neck
___ Arthritis in neck

SHOULDERS:
___ Pain in joint (L) (R)
___ Pain across shoulders
___ Bursitis (L) (R)
___ Arthritis (L) (R)
___ Difficulty raising arm (L) (R)
- ___ Above shoulder level
- ___ Overhead

___ Tension in shoulders
___ Pinched nerve in shoulder (L) (R)
___ Muscle spasms in shoulder

ARMS AND HANDS:
___ Pain in arm
___ Tennis elbow
___ Pain in hands/fingers (L) (R)
___Pins and needles sensation (L) (R)
___ Numbness (L) (R)
___ Cold Hands
___ Loss of grip strength
___ Sore/swollen joints in fingers
___ Arthritis in fingers

MID-BACK:
___ Mid-back pain
___ Pain between shoulder blades
- ___ Sharp, stabbing pain
- ___ Dull ache

___ Muscle spasms
___ Pain in Kidney area

CHEST:
___ Chest pain
___ Shortness of breath
___ Rib pain
___ Breast pain
___ Dimpled breast
___ Irregular heartbeat

ABDOMEN:
___ Nervous stomach
___ Nausea
___ Gas
___ Constipation
___ Diarrhea
___ Hemorrhoids

LOW BACK:
___ Lower back pain
- ___Upper lumbar
- ___Lower lumbar
- ___Sacroiliac

___ Low back pain is worse when
- ___Working
- ___Lifting
- ___Stooping
- ___Standing
- ___Sitting
- ___Bending
- ___Coughing
- ___Lying down
- ___Walking

___ Pain relieved when_____
___ Slipped disc
___ Low back feels out of place
___ Muscle spasms
___ Arthritis

HIPS, LEGS, & FEET
___ Pain in buttocks (L) (R)
___ Pain in hip joint (L) (R)
___ Pain down leg (L) (R)
___ Knee pain (L) (R)
- ___Outside
- ___Inside

___ Leg cramps
___ Feet cramps
___ Pins and needles in legs (L) (R)
___ Numbness in legs/feet (L) (R)
___ Swelling in legs/feet (L) (R)

WOMEN ONLY:
___Menstrual pain
___Cramping
___Irregularity
___Cycle _____Days
___Birth control
___Hysterectomy
___Tumors/Cancer of
_____
___Discharge
___Menopause
___Abortions

MEN ONLY:
___ Increased urinary frequency
___Difficulty starting urination
___Frequent night urination
___Prostate swelling / cancer

GENERAL:
___Nervousness
___Irritable
___Depressed
___Fatigue
___Run-down feeling
___Normal sleep _____hrs
___Loss of sleep
___Loss of weight _____lbs
___Weigh gain _____lbs
___Coffee _____cups/day
___Tea _____cups/day
___Cigarettes _____pack/day
___Diabetes
___Hypoglycemia

REMARKS:

_____

_____

_____

Signature:_____ Date:_____

MERIDIAN CHIROPRACTIC TERMS OF ACCEPTANCE

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

When a person seeks Chiropractic care and we accept a person for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advise, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I,_____ have read and fully understand the above statements.
(print name)

All questions regarding the chiropractors objective to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature: _____ **Date:** _____

Consent to Evaluate and Adjust a Minor Child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature: _____ **Date:** _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and stuff have my permission to perform necessary X-rays. Date of last menstrual period: _____

Signature: _____ **Date:** _____

HIPAA
Notices of Privacy Practices
Meridian Chiropractic of Schaumburg

This notice, effective immediately describes how medical information about you may be used and disclosed and how you can get access to this information, please review carefully. Our office is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment – We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment – We may disclose your health care information to your insurance company provider for the purpose of payment or health care operations. We have your permission to disclose your health care information to your insurance company for the purpose of appealing claims on your behalf.

We may disclose your health care information as necessary to comply with State Workers' Compensation laws, Public Health Authorities, Emergency situations, Judicial and Administrative proceedings, Law Enforcement, Medical examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude and appreciation for referrals, and change of ownership.

We reserve the right to change and amend this Notice of Privacy Practices at any time. Our office is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Compliance Officer by calling (847) 490-9090.

Complaints – Complaints about your privacy rights, or how our office has handled your health information should be directed to our Compliance Officer by calling (847) 490-9090. You may make an appointment for a personal conference in person or by telephone. If you are not satisfied with the manner in which this office handles your complaint, please call (847) 490-9090.

I understand and have been provided with a Notices of Privacy Practices, which provides a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

_____ _____

Patient Name Date

_____

Patient/Guardians Signature