Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Cell Phone: _____ E-mail Address: _____

Social Security # _____ Driver's License Number: _____

Social Insurance # _____ Circle One: Married Single Widowed Divorced Separated

Business Employer: _____ Type of Work: _____

Business Phone: _____ Spouse's Social Security # _____

Name of Spouse _____ Spouse's Social Insurance # _____

Spouse's Employer _____ Business Phone _____

Type of Work _____ Name and Ages of Children _____

Referred To This Office By: _____ _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name) _____ ☐ Health Card # _____

Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____

Other Doctors Seen For This Condition: ☐ Yes ☐ No ____ Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report of Your Accident To Your Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other _____

Do You Wear A Shoe Lift? ☐ Yes ☐ No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other _____

Major Accident or Falls: _____

_____

Hospitalization (Other Than Above): _____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

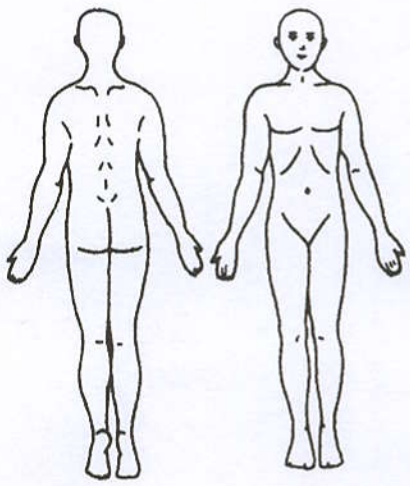
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort.

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____

Doctor's Signature

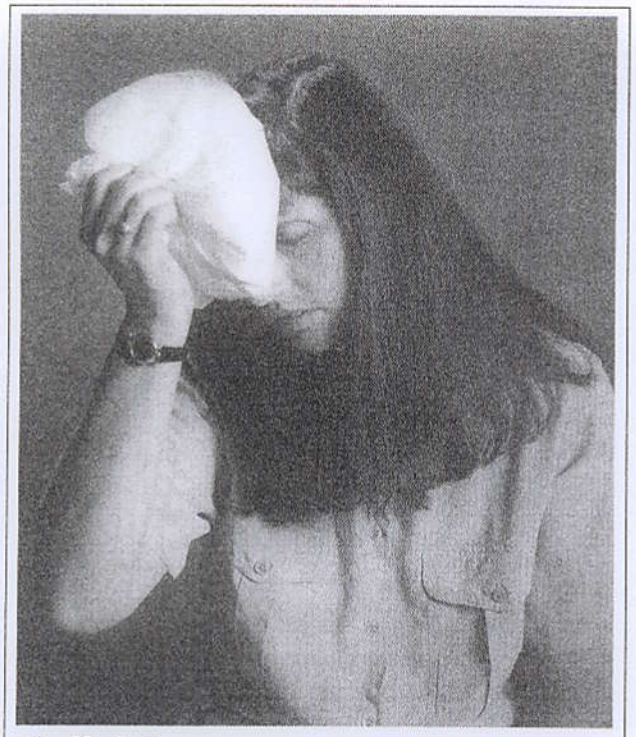
Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ Relief Care
- ☐ Corrective Care
- ☐ Check here if you want the Doctor to select the type of care appropriate for your condition.

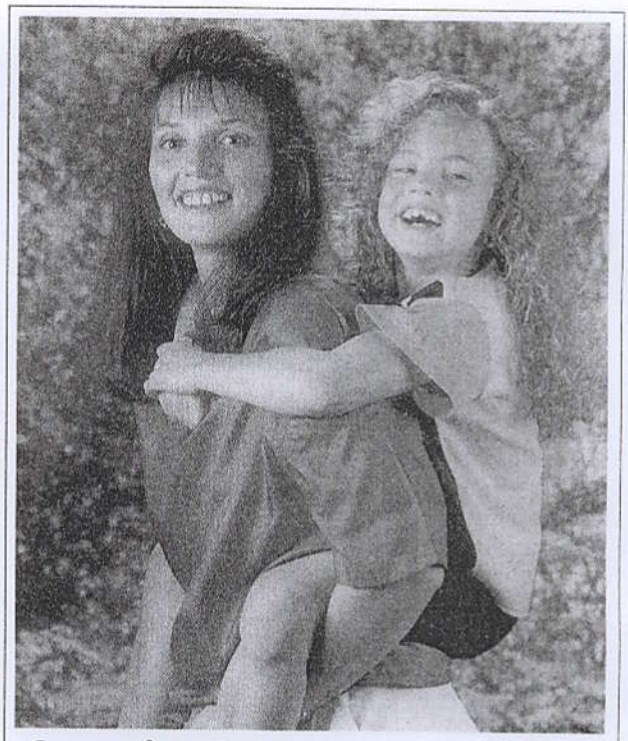
Date _____ Patient's Signature _____

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____ *Date* _____

Consent to Treat a Minor _____ *Date* _____

Guardian or Spouse's Signature of Authorizing Care _____ *Date* _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care we accept a patient 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 patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care 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 eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic 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.

(For Women) Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period _____.

_____ _____
(Signature) (Date)

The Chiropractic Office of Life Mission Chiropractic

Patient Authorization regarding chiropractic care being provided in an "open-door" adjusting environment, sign-in sheets, travel cards, pictures and referral board.

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to that is known as an "incidental disclosures" of health insurance. It is our view that the kinds of matters related in an "open door" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care.

Your signature indicates your authorization of this activity.

_____ _____ _____

Name (Print) Signature Date

Office Policies

1. All first visit charges are payable when services rendered.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary. (One week processing time will be needed – copies will be charged $10.00 per x-ray plate.)
3. Method of payment you plan to use to take care of today's charges? Cash Check Visa/Mastercard/AmEx

I understand and agree that health and accident insurance policies are an arrangement between my auto policy carrier and myself. Furthermore, I understand Life Mission Chiropractic Center will assist in preparing necessary forms to assist in my collections from the insurance company and that any amount authorized to be paid directly to Life Mission Chiropractic Center will be credited to my account upon receipt. *However*, I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account.

Patient Signature_____ Date:_____

Guardian Signature Authorizing Care: _____

In case of emergency, notify: _____ Relationship:_____

Address_____

_____

Phone: _____

Patient Consent for Use and Disclosure
Of Protected Health Information

Life Mission Chiropractic

I hereby give my consent for Life Mission Chiropractic (hereinafter referred to as the "Practice") for use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

The Practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to

Michelle E. Adams, our Privacy Officer, at the following address:

12276 San Jose Blvd., Suite 512, Jacksonville, FL 32223.

With this consent, the Practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian