Patient Health History

Patient Title: *(check one)*❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev. **SSN** _____

First Name _____ **Middle Name**_____ **Last Name** _____

Date of Birth ___/___/___ **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Address 1 _____ **City**_____ **State** _____ **Zip Code** _____

Primary Phone _____**Mobile Phone** _____

Marital Status: ❑ Single❑ Married❑ Other **Spouses Name** _____ **Spouses DOB:** _____

Email _____ ❑ *I authorize my doctor to contact me via the email address provided.*

Employment Status *(check one)*

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

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑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 *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Have you ever received Chiropractic Care? ❑ Yes ❑No If yes, when?_____

Primary reasons for seeking chiropractic care:
Primary reason: _____**Secondary reason:** _____
Previous illnesses you've had in your life: _____
Previous injury or trauma:_____
Have you ever broken any bones? Which? _____
Surgeries and dates: _____

Associated health problem of relatives: _____
Deaths in immediate family: _____
Cause of parents or siblings death and age of: _____

Level of Education _____
Job Description_____
Recreational Activities (including gym) _____
Do you Drink Alcohol? ❑Yes ❑ No If yes, how often?_____

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Chief Complaint: _____
Location of Complaint: _____
What was the initial cause of this complaint? _____
When did this complaint begin? _____
Are you presently under a doctor's care for this complaint? Y/N Doctors name: _____
Please circle the Quality of the complaint pain: dull/aching/sharp/shooting/burning/throbbing/deep/nagging
Does this complaint/pain radiate or travel (shoot) to other areas of your body? Y/N Where? _____
Do you have any numbness or tingling in your body? Where? _____
Grade Intensity/Severity (0 No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (10 Worst possible pain/complaint)
How frequent is complaint present. How long does it last? _____
Does anything aggravate the complaint? _____
Does anything make the complaint better?_____
Does this complaint interfere with:❑ work ❑ home life ❑activities ❑sleep ❑none of the above?_____

On a scale of 1 – 10. How committed are you to resolving this complaint? _____
Are there any other health concerns you would like to address?_____

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 or vitamins, including frequency and dosage if known. If there are no current medications, check here: ❑

		Start Date			Start Date
1)			**5)**		
2)			**6)**		
3)			**7)**		
4)			**8)**		

Do you have any medication allergies? ❑ Yes ❑ No

If yes, please list medications? _____

_____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

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

If yes, other comments regarding Diabetes: _____

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

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I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me/child with chiropractic care, in accordance with this state's statutes.

Patient/Guardian's Signature _____ Date _____

Doctors Signature _____ Date _____

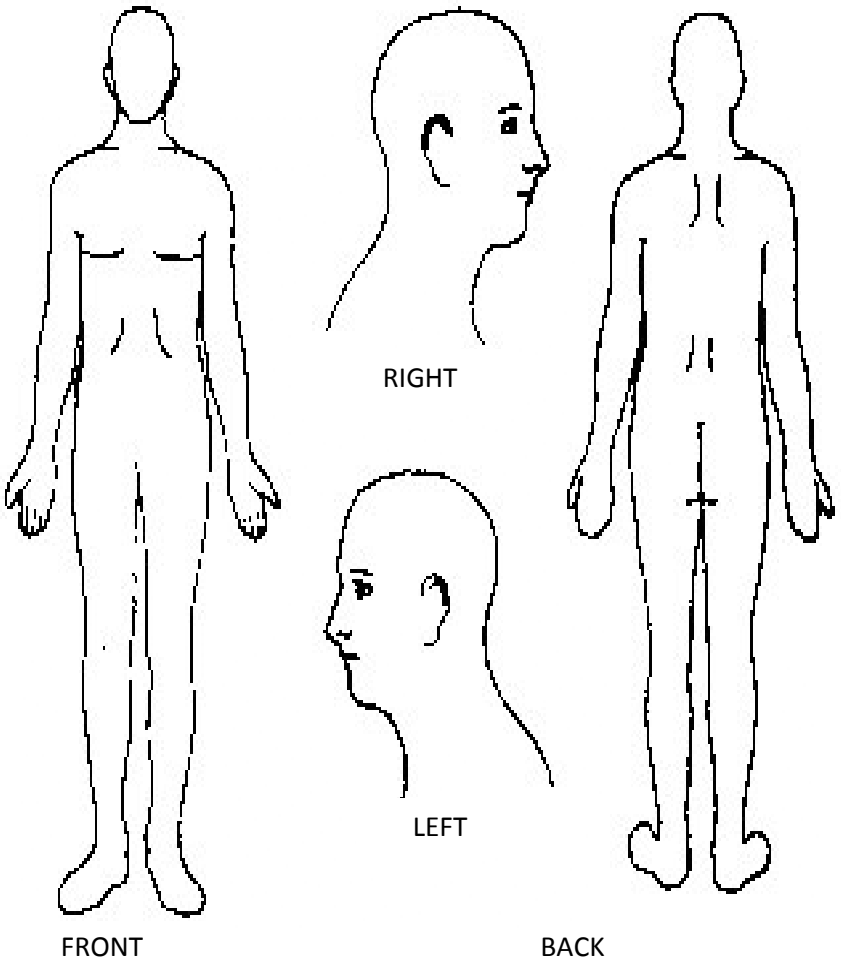
Place an "X" on the drawing over the areas causing you pain and a letter describing it:

X = PAIN

A = ACHE

B = BURNING

S = STABBING



HIPAA Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment
- Obtain payment from third-party payers
- Conduct normal healthcare operations

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at 1941 Hoffman Road, STE 6, Gastonia, NC 28054 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

□ Yes, I would like a copy of your Notice of Privacy Practices
□ No, I would not like a copy of your Notice of Privacy Practices

Patient/Guardian's Signature: _____Date:_____
Printed Name: _____
If signed by other than patient, indicate relationship and reason why patient is unable to sign.

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Consent To Treatment

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

A. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

B. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

C. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed (in person) the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with ___Aaron J. Stump, D.C., CCSP®_____ (health care providers name).

Dated this _____ day of _____ 20___

X_____ _____ Patient signature (or Legal Guardian)

Signature of Witness:_____ Print Name:_____