Quintessential Wellness

PATIENT DATA SHEET

General Information

First Name _____
Middle Initial _____
Last Name _____
Suffix _____
Called Name _____
Address _____
City _____
State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____

Sex Male Female
Race American Indian, Alaska Native, Asian, Black or African America, Native Hawaiian, Other Pacific Islander, White, Declined to State
Ethnicity Declined to State, Hispanic or Latino, Not Hispanic or Latino
Language _____
Marital Status Single Married Other _____

Birthdate _____
Social Security _____
Referred By _____
Work Status Employed Full-time student Part-time student

Appt Reminder Text to Cell/ Voice to Cell/Voice to Home/Email

Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Address _____
City, State, Zip _____

Phone Number _____
Social Security _____
Date of Birth _____
Sex Male Female Unknown

Carrier Information

Name/Code _____

Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____
Fax Number _____
Email Address _____
Web Site _____
Payer ID _____

For Office Use Only

Account Number _____
Account Category _____
Type of Account 1 2 3 4 5 6 7 8 9 Z
Code Set _____
Yearly Deductible _____
Deductible Rest Date _____
Unused Deductible _____
Copay _____
Patient Percentage _____
Cell Phone _____
Household Mailing Yes No
Doctor Number _____
Maximum Charges _____
Max Charge per Day _____
Maximum Visits _____
Max Visits Since Diag _____
Max Treatment Date _____
Full Balance _____
Patient Balance _____
Diagnosis Codes _____

Coverage Information

Coverage Effective Date _____
Coverage Notes _____
Limitations Notes _____

Plan Information

Plan Name _____
Insurance ID _____
Group No _____
Benefits Primary Secondary Other
Coordination _____
Send Form To _____
Claim Type _____

Employer Information

Employer/Code _____
Attn: _____
Address _____
City, State, Zip _____

Contact _____
Phone _____

Condition Information

Related to Employment Yes No
Related to Auto Accident Yes No
Related to Other Accident Yes No
Similar Symptoms _____
Consultation Date _____
Condition Date _____

PRINT NAME: _____ DOB: _____ ACCOUNT #: _____

Quintessential Wellness
Patient Intake Form

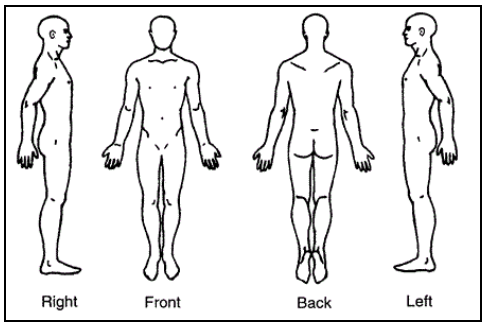
For Office Use Only
HT: _____ WT: _____
TEMP: _____
OXYGEN: _____
BP: _____ PULSE: _____

Name: Date:

Have you ever received chiropractic care? Yes No If Yes, when? _____

Location (Where does it hurt?) **CIRCLE** the area on the illustration.

Symptom 1:



Sharp Shooting Dull Stabbing Aching Burning

Intensity: ○-○-○-○-○-○-○-○-○-○
1 2 3 4 5 6 7 8 9 10

Duration: When did it start? _____

(EX: 1 week ago, 1 month ago)

How did it start? _____

_____

(EX: Gardening, Bending Over, Cleaning)

How often: ◯ Constant (75-100% present)
◯ Frequent (50-75% present)
◯ Occasional (25-50% present)

Radiation: Affect other areas? Where does it radiate, shoot or travel?

_____

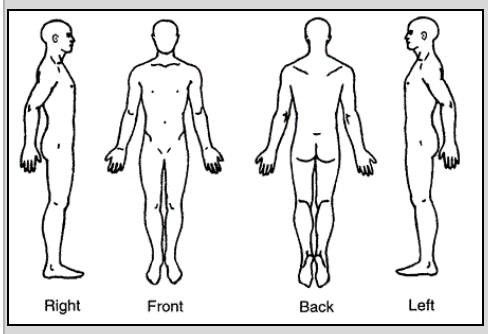
Aggravating or relieving factors: What makes it **better** or **worse**; time of day, movement?

_____

Prior interventions: (what have you tried to relieve this symptom?

◯ Prescription medication ◯ Surgery
◯ Over the counter drugs ◯ Acupuncture
◯ Homeopathic remedies ◯ Chiropractic
◯ Physical Therapy ◯ Massage ◯ Ice/Heat

Symptom 2:



Sharp Shooting Dull Stabbing Aching Burning

Intensity: ○-○-○-○-○-○-○-○-○-○
1 2 3 4 5 6 7 8 9 10

Duration: When did it start? _____

(EX: 1 week ago, 1 month ago)

How did it start? _____

_____

(EX: Gardening, Bending Over, Cleaning)

How often: ◯ Constant (75-100% present)
◯ Frequent (50-75% present)
◯ Occasional (25-50% present)

Radiation: Affect other areas? Where does it radiate, shoot or travel?

_____

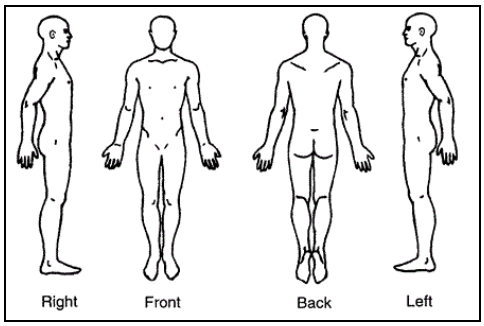
Aggravating or relieving factors: What makes it **better** or **worse**; time of day, movement?

_____

Prior interventions: (what have you tried to relieve this symptom?

◯ Prescription medication ◯ Surgery
◯ Over the counter drugs ◯ Acupuncture
◯ Homeopathic remedies ◯ Chiropractic
◯ Physical Therapy ◯ Massage ◯ Ice/Heat

Symptom 3:



Sharp Shooting Dull Stabbing Aching Burning

Intensity: ○-○-○-○-○-○-○-○-○-○
1 2 3 4 5 6 7 8 9 10

Duration: When did it start? _____

(EX: 1 week ago, 1 month ago)

How did it start? _____

_____

(EX: Gardening, Bending Over, Cleaning)

How often: ◯ Constant (75-100% present)
◯ Frequent (50-75% present)
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Radiation: Affect other areas? Where does it radiate, shoot or travel?

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Aggravating or relieving factors: What makes it **better** or **worse**; time of day, movement?

_____

Prior interventions: (what have you tried to relieve this symptom?

◯ Prescription medication ◯ Surgery
◯ Over the counter drugs ◯ Acupuncture
◯ Homeopathic remedies ◯ Chiropractic
◯ Physical Therapy ◯ Massage ◯ Ice/Heat

PRINT NAME: _____ DOB: _____ ACCOUNT #: _____

What else should the doctor know about your current condition/symptoms?

_____

Do you suffer from any condition other than that for which you are now consulting us? ☐Yes ☐No If yes, please describe:

_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

List any other **PAST** conditions you may have had: _____

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Hypertension	Stroke	Thyroid	Heart Disease	Other	
Mother	❑	❑	❑	❑	❑	❑	❑	❑	Living/Deceased
Father	❑	❑	❑	❑	❑	❑	❑	❑	Living/Deceased
Sibling(s)	❑	❑	❑	❑	❑	❑	❑	❑	Living/Deceased

WORK HISTORY

❑Administration	❑Business Owner	❑Clerical/Secretary	❑Executive/Legal
❑Heavy Equip. Operator	❑Light Manual Labor	❑Construction	❑Computer User
❑Food Service Industry	❑Medium Manual Labor	❑Daycare/Childcare	❑Home Services
❑Manufacturing	❑Heavy Manual Labor	❑Health	❑Housekeeper

❑Other: _____

What type of activities does your work involve?

❑Sitting ❑Standing ❑Bending ❑Turning ❑Twisting ❑Lifting ❑Pulling/Pushing ❑Other: _____

SOCIAL HISTORY

Caffeine use:	❑never	❑occasional	❑often	Drink alcohol:	❑never	❑occasional	❑often
Chew tobacco:	❑never	❑occasional	❑often	Cigarettes:	❑never	❑occasional	❑often
Exercise:	❑never	❑occasional	❑often	Wear Seat Belts:	❑never	❑occasional	❑often

PRINT NAME: _____ DOB: _____ ACCOUNT #: _____

MEDICATIONS

List any supplements/vitamins you are taking: _____

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____ Medication: _____

Route: Oral Route: Oral

Intravenous Intravenous

Other: _____ Other: _____

Frequency: _____ Frequency: _____

Began Use: _____ Began Use: _____

Discontinued Use: _____ Discontinued Use: _____

Medication: _____ Medication: _____

Route: Oral Route: Oral

Intravenous Intravenous

Other: _____ Other: _____

Frequency: _____ Frequency: _____

Began Use: _____ Began Use: _____

Discontinued Use: _____ **Discontinued Use: _____**

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____ Allergy: _____

Reaction: _____ Reaction: _____

Start Date: _____ Start Date: _____

End Date: _____ End Date: _____

Allergy: _____ Allergy: _____

Reaction: _____ Reaction: _____

Start Date: _____ Start Date: _____

End Date: _____ End Date: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		**DATE**		**DATE**	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

Other _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

DATE OF LAST PHYSICAL EXAMINATION: _____

Are you currently pregnant? ❑Yes ❑No Do you have a pacemaker? ❑Yes ❑No

PRINT NAME: _____ DOB: _____ ACCOUNT #: _____

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily

ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

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 of chiropractic to provide me with chiropractic care in accordance with this state's statutes. I understand that it is my responsibility to bring to the attention of the providing physician ANY new information regarding my health and well-being or any changes in health status that would be pertinent to my case management.

Patient's Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

PRINT NAME: _____ DOB: _____ ACCOUNT #: _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requires officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with the quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree you inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, X_____date X_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

PRINT NAME: _____ DOB: _____ ACCOUNT #: _____