

## CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions.  
If you need help, please ask the front desk staff. PLEASE PRINT.

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Marital status: M S W D No. of children: \_\_\_\_\_

Referred by: \_\_\_\_\_ Email address: \_\_\_\_\_

Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Years: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Is this a personal injury case? Yes No Insurance Company: \_\_\_\_\_

Insurance Plan/Group #: \_\_\_\_\_ Your Work Hours: \_\_\_\_\_

Do You Have Medicare? Yes No Medicaid? Yes No

Name of Spouse or Parent: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Describe the Major Complaints That Bring You To Our Office: \_\_\_\_\_  
\_\_\_\_\_

Is your condition due to an accident? Yes No Date of Accident: \_\_\_\_\_

Type of Accident? Auto Work/Job At Home Other: \_\_\_\_\_

## **HEALTH HISTORY**

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

List all current Health Problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any other Doctors seen, Treatments and Results Obtained: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your Current Physician(s)/Therapist(s): \_\_\_\_\_  
\_\_\_\_\_

List all Surgeries and their Dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any Medications you are taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any Traumas and their Dates: \_\_\_\_\_  
\_\_\_\_\_

***Please check the Conditions you have or have had:***

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS            | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Polio         |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Rh. Fever     |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Rh. Arthritis |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Multiple sclerosis  | <input type="checkbox"/> Venereal Dis  |
| <input type="checkbox"/> Depression      | <input type="checkbox"/> Parkinson's Disease |  |

***Please check all Present Symptoms:***

**CARDIOVASCULAR**

- General swelling
- Swelling in legs
- Swelling in face
- Swelling around eyes
- Chest pain
- Heart attack
- High blood pressure
- Pounding/rapid/irregular heart beat
- Blue or purple skin
- Blue or purple nail beds
- Cold hands or feet

**VERTEBROBASILAR**

- Double vision
- Loss of coordination
- Loss of memory
- Ringing in ears
- Muscle weakness
- Dizziness
- Blurred vision
- Taking birth control pills
- Stroke
- Hypertension

- Unable to form words
- Burning sensations
- Blindness
- Previous head injury
- Family history: stroke
- Blood vessel disease
- Check if you smoke
- Fainting
- Areas of numbness
- Previous neck injury

**Please Check All Present Symptoms:**

**Skin, Hair, Nails**

- Eczema
- Itchy skin
- Rough, scaly skin
- Dry skin
- Oily skin
- Yellow skin
- Bruise easily
- Hair loss
- Paper thin nails
- Nail biting

**Eyes**

- Blurred vision
- Double vision
- Eye fatigue
- Excessive tearing
- Lack of tearing
- Light bothers eyes
- Excessive itching
- Pain in eyeball

**Ears**

- Loss of hearing
- Not sufficient
- Pain in the ears
- Discharge from the ears
- Vertigo
- Ringing in ears

**Nose & Sinuses**

- Nose bleeds
- Pressure over eyes
- Nose obstruction
- Frequent colds
- Sinusitis
- Loss of smell
- Allergies

**Mouth & Throat**

- Pain in throat
- Bleeding gums
- Abscessed teeth
- Dentures
- Difficulty swallowing

**Respiratory**

- Shortness of breath
- Dry Cough
- Coughing up blood
- Wheezing
- Productive cough

**Gastrointestinal**

- Poor appetite
- Constant nibbling
- Difficulty swallowing
- Indigestion
- Nausea & vomiting
- Abdominal pain
- Change in bowel habits
- Diarrhea
- Constipation
- Hemorrhoids

**Genitourinary**

- Urination is
  - Frequent
  - Not sufficient
- The amount is
  - High
  - Moderate
  - Low
- Frequent urination at night
- Intense desire to urinate
- Difficulty urinating
- Lack of control
- Pain with urination
- Dribbling
- Bloody urine
- Cloudy urine

**Venereal Disease**

- Syphilis
- Gonorrhea
- Other

**Women Only**

- Painful periods
- Spotting
- Premenstrual symptoms
- Irregular periods
- Lumps in breast/s
- Vaginal discharge
- # of pregnancies \_\_\_\_\_
- # of deliveries \_\_\_\_\_

**Social History**

- Smoking
- Other tobacco use
- Alcohol use
- Drink coffee/tea
- Diet is
  - Balanced
  - Not balanced
- Rest is
  - Sufficient
  - Not sufficient
- Recreation is
  - Sufficient
  - Not sufficient
- Family stress is
  - Severe
  - High
  - Moderate
  - Minimal
  - None
- My job stress is
  - Severe
  - High
  - Moderate
  - Minimal
  - None
- Nervousness
- Irritability
- Fatigue
- Depression
- Panic attacks
- Problems sleeping
- Generally feel run down

***Please Check All Present Symptoms:***

**Head**

- Frequent headaches
- Severe headaches
- Head feels heavy
- Vertigo
- Dizziness
- Light headedness
- Loss of taste
- Loss of smell
- Loss of hearing
- Loss of balance

**Neck**

- Pain in neck
- Pain with movement
- Swelling in neck
- Pinched nerve in neck
- Stiffness in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Limited neck movement

**Mid Back**

- Mid-back pain
- Pain between shoulder blades
  - Sharp/stabbing
  - Dull ache
- Pain from front to back
- Pain over kidney area
- Muscle spasms

**Lower Back**

- Low back pain
- Low back feels out of place
- Muscle spasms

**Shoulders**

- Pain in shoulders
- Pain across shoulders
- Muscle spasms
- Can't raise arm/s
  - Above shoulder/s
  - Above head

**Arms & Head**

- Pain in upper arm
- Pain in forearm
- Pain in hands
- Pain in fingers

**Pins & needles**

- In arms
- In fingers
- Fingers go to sleep
- Cold hands
- Swollen fingers
- Loss of grip strength

**Hips, Legs & Feet**

- Pain in buttocks
- Pain in the hips
- Pain down leg(s)
- Knee pain
- Leg cramps
- Pins & needles in legs/feet
- Numbness in legs
- Numbness in toes
- Cold feet
- Swollen ankles
- Swollen feet

## THE NECK BOURNEMOUTH QUESTIONNAIRE

The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible  
0    1    2    3    4    5    6    7    8    9    10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to perform activity  
0    1    2    3    4    5    6    7    8    9    10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to perform activity  
0    1    2    3    4    5    6    7    8    9    10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious  
0    1    2    3    4    5    6    7    8    9    10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed  
0    1    2    3    4    5    6    7    8    9    10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse  
0    1    2    3    4    5    6    7    8    9    10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever  
0    1    2    3    4    5    6    7    8    9    10

Patient name \_\_\_\_\_ Patient signature \_\_\_\_\_ Date \_\_\_\_\_

## THE BACK BOURNEMOUTH QUESTIONNAIRE

The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible  
0    1    2    3    4    5    6    7    8    9    10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to perform activity  
0    1    2    3    4    5    6    7    8    9    10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to perform activity  
0    1    2    3    4    5    6    7    8    9    10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious  
0    1    2    3    4    5    6    7    8    9    10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed  
0    1    2    3    4    5    6    7    8    9    10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse  
0    1    2    3    4    5    6    7    8    9    10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever  
0    1    2    3    4    5    6    7    8    9    10

Patient name \_\_\_\_\_ Patient signature \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also to give you this Notice while it is in effect. This Notice is effective immediately and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new Notice available upon request.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a chiropractor, physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. Preparing and sending bills or claims; collecting unpaid amounts (either through our office or a collection agency or attorney).

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may remove it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of our best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. We may also disclose to military authorities the health information of Armed Forces personnel under certain circumstances.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contract information listed at the end of this Notice.

**Disclosure Accounting:** You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

## **QUESTIONS AND COMPLAINTS**

If you are concerned that we may have violated your privacy rights, please contact Moscow Health and Wellness Center. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**\*You May Refuse To Sign This Acknowledgment\***

I, \_\_\_\_\_, have received a copy of Moscow Health and Wellness Center's Privacy Practices.

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Signature (Patient or Parent if required)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining

Other (Please specify)

\_\_\_\_\_  
\_\_\_\_\_