

PATIENT HISTORY

NAME _____	TODAY'S DATE ___/___/___ DATE OF BIRTH ___/___/___
SOCIAL SECURITY # _____	MARITAL STATUS S M D W DP
ADDRESS _____	SPOUSE / PARTNER'S NAME _____
CITY _____ STATE ___ ZIP _____	OCCUPATION _____
E-MAIL _____	EMPLOYER _____

PHONE: (H) _____ (CELL) _____ PHONE (W) _____ ext. _____

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT _____

* DATE SYMPTOM FIRST APPEARED _____

* DID IT BEGIN _____ GRADUAL _____ SUDDEN _____ PROGRESSIVE OVER TIME

* WHAT MAKES THE SYMPTOM INCREASE? _____

* WHAT RELIEVES THE SYMPTOM? _____

* TYPE OF PAIN _____ SHARP _____ DULL _____ ACHE _____ BURN _____ THROB

* DO YOU EXPERIENCE NUMBNESS OR TINGLING? _____ Y _____ N

* HOW OFTEN DO YOU EXPERIENCE THESE SYMPTOMS?

_____ 100% _____ 75% _____ 50% _____ 25% _____ 10%

* PAIN INTENSITY: PLEASE PUT A LINE ON THE SCALE DESCRIBING THE INTENSITY OF YOUR PAIN

NO PAIN _____-UNBEARABLE PAIN

OTHER COMPLAINT _____

* DATE SYMPTOM FIRST APPEARED _____

* DID IT BEGIN _____ GRADUAL _____ SUDDEN _____ PROGRESSIVE OVER TIME

* WHAT MAKES THE SYMPTOM INCREASE? _____

* WHAT RELIEVES THE SYMPTOM? _____

* TYPE OF PAIN _____ SHARP _____ DULL _____ ACHE _____ BURN _____ THROB

* DO YOU EXPERIENCE NUMBNESS OR TINGLING? _____ Y _____ N

* HOW OFTEN DO YOU EXPERIENCE THESE SYMPTOMS?

_____ 100% _____ 75% _____ 50% _____ 25% _____ 10%

* PAIN INTENSITY: PLEASE PUT A LINE ON THE SCALE DESCRIBING THE INTENSITY OF YOUR PAIN

NO PAIN _____-UNBEARABLE PAIN

PATIENT HISTORY PART 2

PLEASE LIST ALL PREVIOUS TREATMENTS FOR THIS CONDITION:

NAME OF PRIMARY CARE PHYSICIAN _____ TREATMENT DATES _____

TYPE OF TREATMENT OR DRUGS PRESCRIBED _____

WOULD YOU LIKE US TO UPDATE YOUR PCP REGARDING YOUR CONDITION? Y / N

IF YES, PROVIDE CONTACT INFO _____

NAME OF TREATING PHYSICIAN/SPECIALIST _____ TREATMENT DATES _____

TYPE OF TREATMENT OR DRUGS PRESCRIBED _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? _____ YES _____ NO

NAME OF CHIROPRACTOR _____ DATES OF TREATMENT _____

REASON _____

NAME OF CHIROPRACTOR _____ DATES OF TREATMENT _____

REASON _____

PLEASE LIST ALL PAST SURGERIES:

TYPE _____ DATE _____ DOCTOR _____

TYPE _____ DATE _____ DOCTOR _____

TYPE _____ DATE _____ DOCTOR _____

TYPE _____ DATE _____ DOCTOR _____

PLEASE LIST ALL PREVIOUS ACCIDENTS AND FALLS:

TYPE _____ DATE _____

TYPE _____ DATE _____

TYPE _____ DATE _____

TYPE _____ DATE _____

PLEASE LIST ALL MEDICATIONS OR VITAMINS YOU ARE CURRENTLY TAKING:

TYPE _____ FOR HOW LONG? _____

TYPE _____ FOR HOW LONG? _____

TYPE _____ FOR HOW LONG? _____

TYPE _____ FOR HOW LONG? _____

PATIENT SIGNATURE _____ **DATE** _____

ADVANCED CHIROPRACTIC

Privacy statement: In the course of your care with Advanced Chiropractic, we may disclose personal and health information about you in the following ways:

- Your personal health information, including clinical records may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party such as insurance carrier, HMO, PPO or your employer if they are responsible for the payment of your services.
- Your name, address, phone number and health care records may be used to contact you regarding appointment reminders, birthday cards, and information about alternatives to your present care or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement associated with your care.

Under federal law, we are also permitted or required to disclose your health information without your consent under the following circumstances:

- If we are providing health care service to you based on the order of another health care provider
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered to by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above will only be made upon your written authorization. We normally provide information about your health information for seven years from this date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing. You have the right to inspect and/ or copy your health information for 7 years from this date or as long as the information remains in our files. In addition you have the right to request an amendment to your health information in our files.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required by law to abide by the terms of this privacy notice. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, or if you would like further information about our privacy policies and practices, you should direct your complaints or questions to Dr. Alexander Jamieson or Dr. Lesley Freedman. You may also file a complaint at www.HHS.gov/ocr/HIPPA

This notice is effective as of April 15, 2003. This notice and any alteration or amendments made hereto will expire 7 years from the date upon which the record was created.

My signature acknowledges that you have received a copy of this notice.

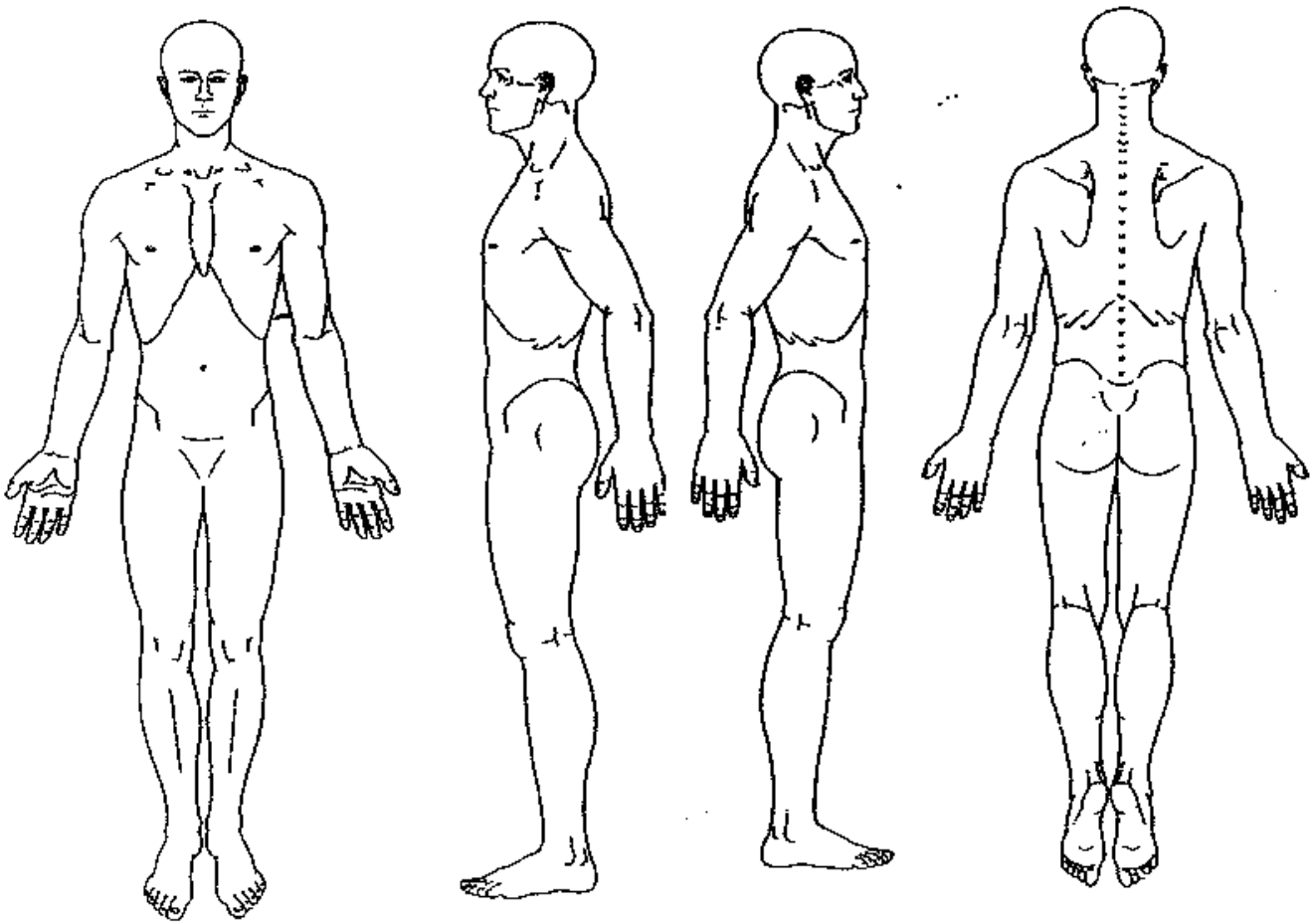
Name (printed)

Signature

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

PAIN DIAGRAM



Please mark the areas of your complaint on the diagram above.
Please use the following symbols to accurately describe your condition:

- | | |
|-----|-------------------------------|
| PPP | Where you experience PAIN |
| NNN | Where you experience NUMBNESS |
| TTT | Where you experience TINGLING |
| BBB | Where you experience BURNING |
| CCC | Where you experience CRAMPING |

PATIENT SIGNATURE _____ DATE _____