Patient Profile

Full Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____ Social Security #: _____

Email Address: _____

Employer: _____ (Circle One) Full Time / Part Time

Emergency Contact: _____ Number: _____

How did you hear about our office? _____

Marital Status (Circle one): Single / Married / Widowed / Divorced

Are you a full time student? (Circle one) YES / NO

Do you have health insurance? (Circle one) YES / NO

Insurance Company: _____

Identification #: _____

Policy Holders DOB: _____

Who is the responsible party? (Circle One):
You / Other (parent, spouse, etc.) _____

Electronic Health Record Intake Form

In compliance with requirements for the government EHR incentive program

Preferred method of communication (circle one) Email Phone Mail

DOB: ____/_____/_____ **Gender (Circle One):** Male / Female Language: _____

Smoking status (Circle one): Every day smoker Occasional Smoker Former Smoker Never Smoked

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White
Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / Decline to answer

Are you currently taking any medications? (Please include regularly used over the counter medications too)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Height: _____ **Weight**: _____ **Blood Pressure**: _____

Patient Signature: _____ **Date**: _____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that Druzbik Family Chiropractic "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Druzbik Family Chiropractic "Notice of Privacy Practices" prior to signing this document. This notice of privacy practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills of in the performance of health care operations of Druzbik Family Chiropractic.

The Notice of Privacy Practices for Druzbik Family Chiropractic is also provided on request at the main administration desk of this practice. The Notice also describes my rights and Druzbik Family Chiropractic duties with respect to my protected health information.

Druzbik Family Chiropractic reserves the right to change the privacy policy that are described in the Notice of Privacy Practices. I may obtain a revised copy by calling the office and requesting it to be sent in the mail or by asking for on at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that Druzbik Family Chiropractic has taken in action in reliance on this consent.

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by Michael Druzbik, DC and/or other licensed doctors of chiropractic who now or in the future work at Druzbik Family Chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic name above and/ or other office or clinical personal that nature the purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks but the information is provided so that I may make an informed decision.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms:

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Chief Complaint Form

Describe the reason for your visit: _____

_____

_____

_____

When did your symptoms begin: (Circle One) Today This Week Within last 3 weeks 3 months to 6 months

6 months to 1 year More than 1 year

Women Only: Most recent menstrual cycle: ___/___/___ Are you pregnant? Yes No

Which word describes the frequency of your disorder? (Circle one) Constant Intermittent

Occasional Rare

Which phrase best describes changes in your discomfort during the day? (Circle One)

Worse in the morning worse in the afternoon worse at night

Changes with the weather does not change

What helps relieve your discomfort? (Circle one) Ice Heat Medication

What activities are limited by your discomfort? (Select all that apply)

Bending	bowel movements	coughing	daily routine
Driving	getting up	lifting	lying down
Pulling	pushing	reading	sitting
Sleeping	sneezing	standing	turning my head
Urination	walking	working	other_____

Most recent: Physical Exam: ___/___ Spinal X-rays: ___/____ MRI: ____/____

CT Scan: ___/___ Other Scans or x-rays:___/___

DRUZBIK FAMILY CHIROPRACTIC

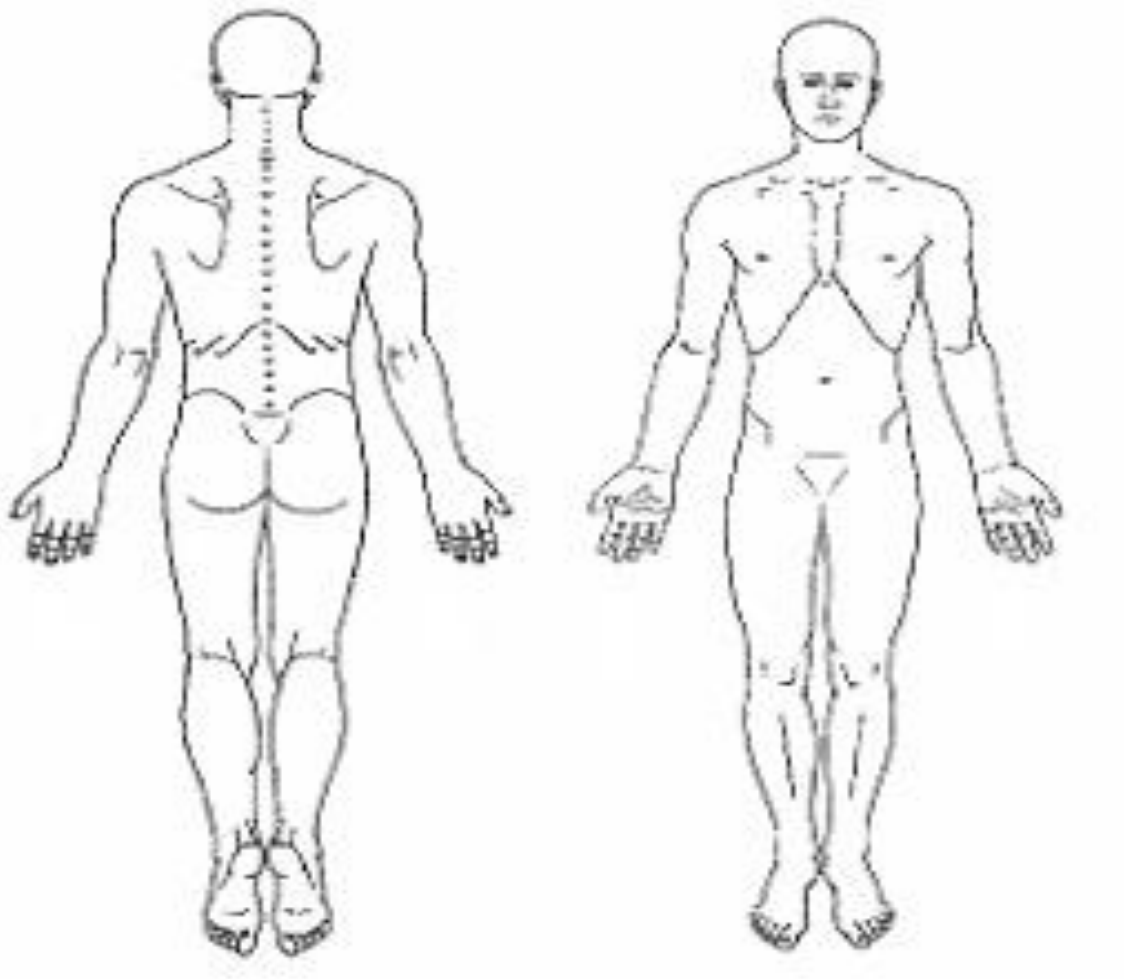
On a scale of 1 to 10, please rate your pain for today. Circle one:

0 1 2 3 4 5 6 7 8 9 10

Little pain Moderate Pain Severe Pain

Please mark where you are hurting:

Left Right Left Right



DRUZBIK FAMILY CHIROPRACTIC

Indicate if you had or now have any of the following symptoms/conditions:

Condition	Now	Past
Headaches		
Neck Pain		
Upper Back Pain		
Mid Back Pain		
Lower Back Pain		
Shoulder Pain		
Elbow/Arm Pain		
Wrist Pain		
Hand Pain		
Hip/Upper Leg Pain		
Knee/Lower Leg Pain		
Ankle/Foot Pain		
Jaw Pain/ TMJ		
Joint Swelling/Stiffness		
Arthritis		
Rheumatoid Arthritis		
General Fatigue		
Ringing in Ears		
Visual Disturbances		
Dizziness		
High BP		
Heart Attack		
Chest Pains		
Stroke		
Angina		
Kidney Stones		
Kidney Disorder		
Bladder Infection		
Painful Urination		

Condition	Now	Past
Loss of Bladder Control		
Prostate Problems		
Abnormal Pain		
Ulcer		
Hepatitis		
Liver/Gall Bladder Disorder		
Cancer		
Tumor		
Asthma		
Chronic Sinusitis		
Seasonal Allergies		
Diabetes		
Excessive Thirst/Urination		
Thyroid Disorder		
Smoking/Tobacco Use		
Drug/Alcohol Use		
Food Allergies		
Depression		
Frequent Illness		
Epilepsy		
Dermatitis/Eczema/Rash		
HIV/AIDS		
Females Only:		
Hot Flashes		
Hormone Replacement		
Birth Control Pills		
Painful Periods/Cramps		
Are you pregnant?	YES	NO
Due Date:		

List all surgical procedures you have had and times you have been hospitalized:

_____
_____
_____
_____
_____

Detail any history of trauma to head, neck, or back (auto accidents, sports injuries, work-related accidents, etc.):

_____
_____
_____
_____
_____