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 receptionist. PLEASE PRINT.

Todayôs Date:_____

Name: _____ Home Phone:_____

Address:_____ City: _____ State: _____ Zip: _____

Age:_____ Birth Date: _____ Marital Status: M S W D No. of Children _____

Referred by: _____ E-mail Address: (appointment reminders)_____

Your Employer: _____ Occupation: _____ Years on Job: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Cell Phone: _____

Do You Have Health Insurance? ☐ Yes ☐ No Insurance Company: _____

Insurance Plan/ID#: _____ Your Work Hours: _____

Do You Have Medicare? ☐ Yes ☐ No Medicaid? ☐ Yes ☐ No

Name of Spouse or Parent: _____ Birth Date: _____

Spouseôs 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: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ *Date:* _____

Guardian's Signature (For Minors): _____ *Date:* _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

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:

( ) AIDS
( ) Anemia
( ) Arthritis
( ) Cancer
( ) Chronic fatigue
( ) Depression
( ) Diabetes
( ) Epilepsy
( ) Fibromyalgia
( ) Hypoglycemia
( ) Multiple sclerosis
( ) Parkinson's disease
( ) Polio
( ) Rheumatic fever
( ) Rheumatoid arthritis
( ) Tuberculosis
( ) Venereal disease

Please Check All Present Symptoms:

CARDIOVASCULAR
( ) General swelling
( ) Swelling in legs
( ) Swelling in face
( ) Swelling around eyes
( ) Chest pain
( ) Pounding heart beat
( ) Rapid heart beat
( ) Irregular heart beat
( ) Blue or purple skin
( ) Blue or purple nail beds
( ) Cold hand/feet

VERTEBROBASILAR
( ) Double vision
( ) Loss of coordination
( ) Loss of memory
( ) Ringing in ears
( ) Heart attack
( ) High blood pressure
( ) Muscle weakness
( ) Dizziness
( ) Blurred vision
( ) Stroke
( ) Hypertension
( ) Inability to form words
( ) Burning sensations
( ) Blindness
( ) Previous head injury
( ) Previous neck injury
( ) Taking birth control pills
( ) Family history of stroke
( ) Blood vessel disease
( ) Check if you smoke
( ) Fainting
( ) Area of numbness

MUSCULOSKELETAL SYSTEM

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
( ) Stiffness in neck
( ) Pinched nerve 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 pain
( ) Dull ache
( ) Pain from front to back
( ) Pain over kidney area
( ) Muscle spasms

Lower Back
( ) Lower back pain
( ) Lower back feels out of place
( ) Muscle spasms

Shoulders
( ) Pain in shoulders
( ) Pain across shoulders
( ) Muscle spasms
( ) Can't raise arm
( ) Above shoulder
( ) Above head

Arms & Hands
( ) 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 hip
( ) Pain down leg
( ) Knee pain
( ) Leg cramps
( ) Pins & needles in legs
( ) Numbness in legs
( ) Numbness in toes
( ) Cold feet
( ) Swollen ankles
( ) Swollen feet

REVIEW OF SYSTEMS

Please Check All Present Symptoms:

Skin, Hair, Nails
( ) Eczema
( ) Itchy skin
( ) Rough, scaly skin
( ) Dry skin
( ) Oily skin
( ) Yellow skin
( ) Bruise easily
( ) Baldness
( ) 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

Ear
( ) Loss of hearing
( ) Not sufficient
( ) Pain in ears
( ) Discharge from 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
( ) vaginal discharge
# of pregnancies _____
# of deliveries _____

Social History
( ) Smoking
( ) Other tobacco use
( ) Alcohol use
( ) Drink coffee or 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
( ) Moderate
( ) Minimal
( ) None

( ) Nervousness
( ) Irritability
( ) Fatigue
( ) Depression
( ) Panic attacks
( ) Problems sleeping
( ) Generally feel run-down

HIPPA NOTICE OF PRIVACY PRACTICES
Total Health Chiropractic and Acupuncture
1000 Lake Saint Louis Blvd Suite 129
Lake St. Louis, MO 63367
636-695-4570

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1.Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: As Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy official of your complaint. We will not retaliate against you for filing a complaint. You can contact our privacy official at: 1000 Lake Saint Louis Blvd Suite 129Lake St Louis, MO 63367

This notice was published and became effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME:_____SIGN: _____DATE:_____