New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date of Injury | Date symptoms appeared

Have you ever had same condition? ◯ No ◯ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ◯ No ◯ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ◯ No ◯ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ◯ No ◯ Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? ◯ No ◯ Yes

Have you had X-rays taken? ◯ No ◯ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	◯	◯	
Been hospitalized?	◯	◯	
Been in an auto accident?	◯	◯	
Had Sprains/Strains?	◯	◯	
Been struck unconscious?	◯	◯	
Had surgery?	◯	◯	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	◯ No	◯ Yes
Do your symptoms interfere with daily life?	◯ No	◯ Yes
Does pain wake you up at night?	◯ No	◯ Yes
Are your symptoms worse during certain times of the day?	◯ No	◯ Yes
Do changes in weather affect your symptoms?	◯ No	◯ Yes
Do you wear orthotics?	◯ No	◯ Yes
Do you take vitamin supplements?	◯ No	◯ Yes

What activities aggravate your symptoms?

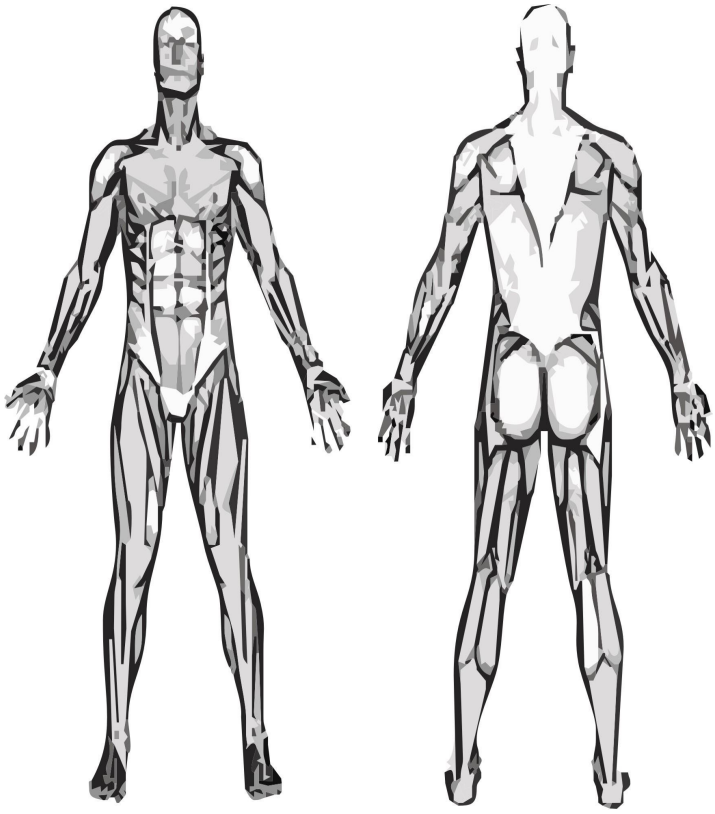
Habits	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Appetite	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯
Salty Foods	◯	◯	◯	◯
Sugary Foods	◯	◯	◯	◯
Artificial Sweeteners	◯	◯	◯	◯

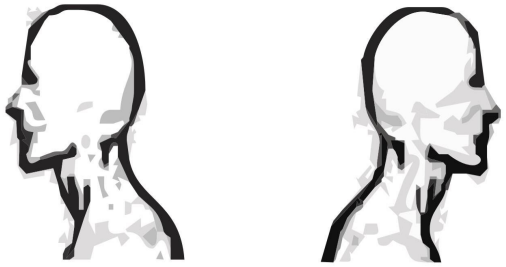
Have you ever suffered from:

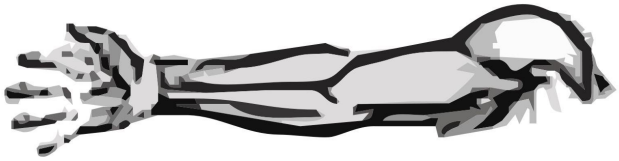
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing







INFORMED CONSENT

CHIROPRACTIC, AS WELL AS OTHER TYPES OF HEALTH CARE, IS ASSOCIATED WITH POTENTIAL RISKS IN THE DELIVERY OF TREATMENT. THEREFORE IT IS NECESSARY TO INFORM THE PATIENT OF SUCH RISKS PRIOR TO INITIATING CARE. WHILE CHIROPRACTIC TREATMENT IS REMARKABLY SAFE, YOU NEED TO BE INFORMED ABOUT THE POTENTIAL RISKS RELATED TO YOUR CARE TO ALLOW YOU TO BE FULLY INFORMED IN CONSENTING TO TREATMENT.

CORBETT CHIROPRACTIC & HEALTH ENHANCEMENT USES TRAINED STAFF PERSONNEL TO ASSIST WITH PORTIONS OF YOUR CONSULTATION, EXAMINATION, X-RAYS, PHYSICAL THERAPY APPLICATION, EXERCISE INSTRUCTION, ETC. OCCASIONALLY, WHEN YOUR CHIROPRACTOR IS UNAVAILABLE, ANOTHER QUALIFIED DOCTOR OF CHIROPRACTIC MAY TREAT YOU.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

STROKE - STROKE IS THE MOST SERIOUS COMPLICATION OF CHIROPRACTIC TREATMENT. IT IS, ON RARE OCCASIONS, DUE TO INJURY OF THE VERTEBRAL ARTERY CAUSED BY A CERVICAL SPINE ADJUSTMENT OR MANIPULATION, AND WHEN OCCURS, MAY CAUSE TEMPORARY OR PERMANENT BRAIN DYSFUNCTION. ON EXTREMELY RARE OCCASIONS DEATH OCCURS. BECAUSE THE VERTEBRAL ARTERIES, WHICH SUPPLY THE BRAIN WITH BLOOD, ARE LOCATED WITHIN THE BONES OF THE CERVICAL SPINE, CERVICAL TREATMENT POSES A SMALL RISK. THE CHANCES OF THIS OCCURRING ARE ESTIMATED AT 1 PER 400,000 TREATMENTS TO 1 PER 10 MILLION TREATMENTS. THE MOST RECENT STUDIES (JOURNAL OF THE CCA, VOL. 37, NO.2, JUNE, 1993) ESTIMATE THAT THE INCIDENCE OF THIS TYPE OF STROKE IS 1 IN EVERY 3 MILLION UPPER CERVICAL ADJUSTMENTS.

SORENESS- CHIROPRACTIC ADJUSTMENTS AND PHYSICAL THERAPY PROCEDURES ARE SOMETIMES ACCOMPANIED BY POST TREATMENT SORENESS. THIS IS A NORMAL AND ACCEPTABLE ACCOMPANYING RESPONSE TO CHIROPRACTIC CARE. WHILE IT IS NOT GENERALLY DANGEROUS, PLEASE ADVISE YOUR DOCTOR OF CHIROPRACTIC IF YOU EXPERIENCE SORENESS OR DISCOMFORT.

SOFT TISSUE INJURY - OCCASIONALLY CHIROPRACTIC TREATMENT MAY AGGRAVATE A DISC INJURY, OR CAUSE OTHER MINOR JOINT, LIGAMENT, TENDON, OR OTHER SOFT TISSUE INJURY.

RIB INJURY - MANUAL ADJUSTMENTS TO THE THORACIC SPINE, IN RARE CASES, MAY CAUSE RIB INJURY OR FRACTURE. PRECAUTIONS SUCH AS PRE-ADJUSTMENT X-RAYS ARE TAKEN FOR CASES CONSIDERED AT RISK. TREATMENT IS PERFORMED CAREFULLY TO MINIMIZE SUCH RISK.

PHYSICAL THERAPY BURNS - HEAT GENERATED BY PHYSICAL THERAPY MODALITIES MAY CAUSE MINOR BURNS TO THE SKIN. THESE ARE RARE, BUT SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC OR STAFF IF THEY OCCUR.

OTHER PROBLEMS - THERE ARE OCCASIONALLY OTHER TYPES OF SIDE EFFECTS ASSOCIATED WITH CHIROPRACTIC CARE. WHILE THESE ARE RARE, THEY SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC OR STAFF PROMPTLY.

PREGNANT PATIENTS SHOULD NOT BE X-RAYED. IF X-RAYS ARE PERFORMED ON A PREGNANT PATIENT, SIDE EFFECTS TO THE FETUS/INFANT MAY RESULT. I, THE PATIENT, UNDERSTAND THAT IT IS UP TO ME TO INFORM THE DOCTOR OF CHIROPRACTIC IF I AM PREGNANT. IF FOR SOME REASON X-RAYS ARE PERFORMED AND I AM PREGNANT, I WILL NOT HOLD DR. DANIEL G. CORBETT OR CORBETT CHIROPRACTIC & HEALTH ENHANCEMENT RESPONSIBLE FOR ANY SIDE EFFECTS THAT MAY RESULT.

CHIROPRACTIC IS A SYSTEM OF HEALTH CARE DELIVERY AND THEREFORE, AS WITH ANY HEALTH CARE DELIVERY SYSTEM, WE CANNOT PROMISE A CURE FOR ANY SYMPTOM, CONDITION, OR DISEASE AS A RESULT OF TREATMENT IN THIS OFFICE. AN ATTEMPT TO PROVIDE THE VERY BEST CARE IS OUR GOAL AND IF THE RESULTS ARE NOT ACCEPTABLE. WE WILL REFER YOU TO ANOTHER PROVIDER WHO WE FEEL WILL ASSIST YOUR SITUATION.

IF YOU HAVE ANY QUESTIONS CONCERNING THE ABOVE, PLEASE ASK YOUR DOCTOR OF CHIROPRACTIC. WHEN YOU HAVE FULL UNDERSTANDING AND CONSENT TO CARE PROVIDED, PLEASE PRINT YOUR NAME, SIGN AND DATE BELOW.

HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE CHIROPRACTIC TREATMENT ADMINISTERED.

PATIENT'S NAME PRINTED

TODAY'S DATE

PATIENT'S SIGNATURE

PARENT OR GUARDIAN SIGNATURE FOR MINOR

Corbett Chiropractic & Health Enhancement

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

For further information regarding this notice, please contact Dr. Corbett at 507-645-8846