PChiropractic Health Questionnaire

2050 WOODSON RD.
OVERLAND, MO 63114
(314)-447-0725 (314)-447-0726 fax
Proficientchiropractic.com/proficientchiro@gmail

Name:_____ **Date:**_____
Address:_____**City:**_____**State:**_____**Zip Code:**_____
Home Phone: (___)_____ **Cell Phone: (___)**_____ **Mobile Carrier:**_____
SS#:_____ **Birthdate:**_____ **Male:**____ **Female:**_____
Occupation:_____ **Employer:**_____
Email: _____ **Work Phone: (___)**_____
Marital Status: **Separated__ Married__ Divorced__ Widowed__ Single:__ Student:__**
Who referred you to our office?_____

Your Health Profile

1. Science tells us your spine should be cared for regularly. How often do you get adjusted by a chiropractor?
   □ Frequently □ Only when you hurt □ 1 X month □ Never

2. When was your last complete spinal examination including x-rays?_____ □ Never

3. On a daily basis we experience physical trauma, chemical toxins and emotional stresses that can accumulate and result in a serious loss of our health potential. In most cases the effects are gradual, not even felt until they become serious.

	Yes	No
Do/ Did you smoke?	☐	☐
Do/ Did you drink alcohol?	☐	☐
Have you been involved in any accidents (auto, work, sports, falls)?	☐	☐

   If so, please describe:_____
   _____

4. Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck?
   □ Yes □ No

5. Poor posture leads to poor health and early death. How would you rate your posture?
   Poor 1 2 3 4 5 6 7 8 9 10 Excellent

6. Improper sleeping positions can cause spinal damage, what sleeping position do you sleep in:
   □ Back □ Stomach □ R Side □ L Side

7. Stress will cause you to accelerate spinal damage. Rate your stress level over the last 3 months.
   Calm/Relaxed 1 2 3 4 5 6 7 8 9 10 Very Tense/Tight

8. What is your exercise/activity level: Never 1 2 3 4 5 6 7 8 9 10 High Activity Level

9. Surgeries can be traumatic and cause weakness to muscles & soft tissue. Please list all surgeries?
   _____

10. **(For women only)** Are you pregnant?: □ Yes □ No

11. Prescription Medications cause side effects and hide the severity of health problems hindering the body's ability to heal. What medications are you currently taking? (use back or attach copy)

_____

Your Current Health Status

1. On a scale of 1-10 rate your current state of health: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

2. List your chief complaints in order of severity:
   1. _____ For how long: _____
   2. _____ For how long: _____
   3. _____ For how long: _____

(Please check all activities below that are affected by your problem:)

3. Does it interfere with:

☐ Work	☐ Sleep	☐ Stand	☐ Sit	☐ Getting Dressed
☐ Climb Stairs	☐ Walk	☐ Yard Work	☐ Driving	☐ Read/Concentrate
☐ Laundry	☐ Lifting	☐ Bending	☐ Carrying	☐ Washing/Bathing
☐ Exercise	☐ Intimacy	☐ House Work	☐ Squating	☐ House Work

4. Rate your pain on a scale of 1-10 (10 being worst) 1._____ 2._____ 3._____

5. Are you wanting to patch up your problem or achieve more of a permanent solution if possible?_____

6. Other health care providers seen for this condition:_____

7. If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely? □ Yes □ No

Please Check All That Apply

Please check all symptoms you have ever had, even if they don't seem related to your current problem.

☐ Headaches	☐ Pain/Numbness in legs/feet	☐ Neck Pain	☐ Tension in the Neck
☐ Back pain	☐ Loss of balance	☐ Dizziness	☐ Stiff/Tight Neck
☐ Ringing in the ears	☐ Pain/Numbness in hands	☐ Nervousness	☐ Carpal Tunnel
☐ Migraines	☐ Chronic Fatigue	☐ Digestive Problems	☐ Disc Problems
☐ Depression	☐ Irritability	☐ Sleeping Problems	☐ Diabetes
☐ Lack of concentration	☐ Mood swings	☐ Bladder Problems	☐ Prostrate Problems
☐ Menstrual problems	☐ High Blood Pressure	☐ Asthma	☐ Cardiovascular Ds.

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and friends. If you have friends and family members that would be interested in having any of their health conditions or concerns evaluated by a Wellness Chiropractor, please mention their name and number below:

Family Members: 1._____ 2._____

Friends: 1._____ 2._____

Your Wellness Profile

	Yes	No
Do you belong to a gym/health club?	☐	☐
Do you take supplements/vitamins?	☐	☐
Do you pray/meditate daily?	☐	☐
Do you practice stretch/yoga?	☐	☐

Financial

PAYMENT IS DUE AS SERVICES ARE RENDERED

All services are due when rendered, unless other arrangements have been made prior to treatment.

Method of payment: Cash: _____ Check: _____ Credit Card: _____ HSA: _____ Insurance: _____

Group Insurance

Patients are responsible for payment at the time of their visit, unless other arrangements have been made prior to treatment. As a courtesy we will verify your insurance. Verification is not a guarantee of payment. The insurance contract is between the patient and the insurance company. We do accept assignment once verification of coverage has been made. You are responsible for any unpaid balance by your insurance company.

Insurance company: _____ Policy #: _____

Group #: _____ Insurance Phone: _____

Medicare

The doctor is a participating Medicare provider. Medicare patients are required to complete an Advance Beneficiary Notice of Non-coverage (ABN) form prior to treatment. Medicare patients must present their Medicare card at the onset of treatment. Medicare covers only Acute care.

Personal Injury

While under care in our office if you become involved in a personal injury claim, please inform us immediately, so that we may take the proper steps to insure that your case is addressed appropriately.

The information made on this form is accurate & I agree to allow this office to examine me for further evaluation:

Signature:_____ Date:_____

HIPAA Notice of Privacy Practices

[Name]_____

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

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, the 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 or 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 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 contact of your complaint. **We will not retaliate against you for filling a complaint.**
This notice was published and becomes effective on/or before **April 14, 2003.**

PROFICIENT CHIROPRACTIC
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Dr. Edgar Everett, III Dr. Xaivier T. Tipler Chiropractic Physician Chiropractic Physician

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 HIPAA 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:_____Signature_____ Date_____