

PATIENT INFORMATION

PATIENT'S NAME: _____ **CIRCLE: MALE / FEMALE**

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: ____ - ____ - ____ **CELL:** ____ - ____ - ____ **SS#:** ____ - ____ - ____

D.O.B. ____/____/____ **HOW DID YOU HEAR ABOUT US?** _____

EMAIL ADDRESS : _____

EMERG. CONTACT: _____ **EMERGENCY #:** ____ - ____ - ____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMPLOYER'S #: ____ - ____ - ____ **FAX:** ____ - ____ - ____

DATE OF INJURY: ____/____/____

PRIMARY COMPLAINT: _____

Do you have vertigo (dizziness)?
Yes No
 Do you pass out easily (faint or loss of consciousness)?
Yes No
 Do you have double vision or have you lost sight in one eye?
Yes No
 Do you have any slurred speech or difficulty with speech?
Yes No
 Do you have or have you ever had difficulty in arranging words properly?
Yes No
 Do you have any difficulty walking, with coordination or falling to one side?
Yes No
 Do you have nausea or vomiting?
Yes No
 Do you have numbness on one side of your face or body?
Yes No
 Do you have any visual disturbances or rapid eye movement?
Yes No
 Do you have a headache or head pain that is unlike any you have had before?
Yes No
 Do you have headaches for hours or days?
Yes No
 Do you have a history of stroke in your family?
Yes No
 Do you have chest pain?
Yes No
 Do you have any change in bowel or bladder habits?
Yes No
 Do you have a sore that does not heal?
Yes No
 Do you have any unusual bleeding or discharge?

Yes No
 Do you have any thickening in your breasts or elsewhere?
Yes No
 Do you have indigestion or difficulty swallowing?
Yes No
 Do you have a change in any wart or mole?
Yes No
 Do you have a nagging cough or hoarseness?
Yes No
 Do you have night sweats?
Yes No
 Do you have pain in neck, jaw or face?
Yes No
 Do you have a drooping eyelid or change in your pupils?
Yes No
 Do you have any ringing in your ears?
Yes No
 Do you take birth control pills?
Yes No
 Have you ever had cancer?
Yes No
 Does your pain ever wake you from a sound sleep?
Yes No
 Are you losing weight now without trying?
Yes No
 Are you coughing up blood or noticing it in your stools or urine?
Yes No
 Have you had any loss of bladder or bowel control?
Yes No
 Have you lost consciousness or had double vision recently?
Yes No
 Are you seeing any other doctor now for any reason?
Yes No

Are you taking any medication or over-the-counter drugs?

Please indicate type (aspirin, etc.) _____

What prescription medication are you taking if any?

High blood pressure medication

Blood thinners

Other _____

What was the date of onset of your last menses? _____

Social History

SMOKER _____ Yes or _____ No, If Yes, how many packs _____

ALCOHOL _____ Yes or _____ No, If Yes, how much _____

Family History

Did your mother or father have any of the following:

Put an **M** for mother, **F** for father and **B** for both.

() High Blood Pressure

() Ulcer or Stomach Problems

() Heart Attack

() Stroke

() Emphysema

() Arthritis-Rheumatism

() Seizure-Convulsions

() Mental Illness

() HIV Positive

() Thyroid Disease

() Asthma

() Circulation Problems

() Diabetes

() Cancer

() Kidney Disease

HEALTH COMPLAINTS

Are you here because you were injured in a motor vehicle accident, while working or because of another traumatic incident? Yes No

What is your primary complaint?

How long have you been experiencing this complaint? _____

Describe the quality of you primary complaint.

Sharp Dull/achy Numb Tightness Tingling Burning Cold Weakness

How often do you experience this complaint? Constantly Intermittent

Have you missed work because of your primary complaint? Yes No

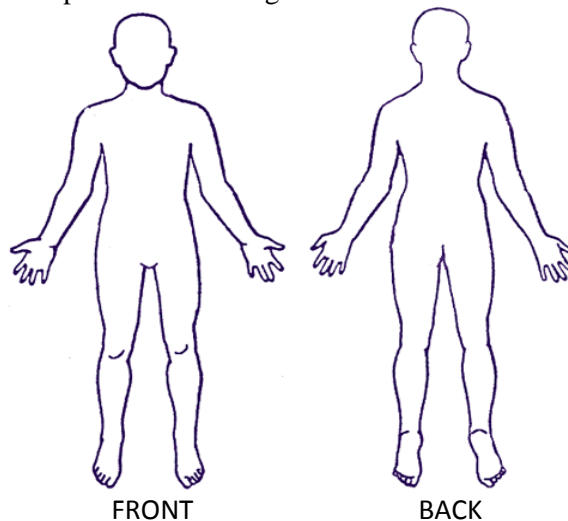
Treatment thus far for your primary complaint:

Have you ever had this complaint before? Yes No

If yes, what treatment was used?

Please list any other health complaints:

Please mark areas of all your complaints on the diagrams below:



Patient Name: _____ Date: __/__/____	Overall Energy (Lung, Kidney Function) <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty keeping eyes open in the day <input type="checkbox"/> General weakness <input type="checkbox"/> Easily catch cold <input type="checkbox"/> Low energy <input type="checkbox"/> Feel worse after exercise
Overall Temperature (Kidney Function) <input type="checkbox"/> Cold hands <input type="checkbox"/> Cold fingers <input type="checkbox"/> Cold feet <input type="checkbox"/> Cold toes <input type="checkbox"/> Sweaty hands <input type="checkbox"/> Sweaty feet <input type="checkbox"/> Hot body temperature (sensation) <input type="checkbox"/> Cold body temperature (sensation) <input type="checkbox"/> Afternoon flushes <input type="checkbox"/> Night sweats <input type="checkbox"/> Heat in the hands, feet and chest <input type="checkbox"/> Hot flashes any time of the day <input type="checkbox"/> Thirsty <input type="checkbox"/> Perspire easily <input type="checkbox"/> Lack of perspiration <input type="checkbox"/> Take water to bed	Heart Function <input type="checkbox"/> Anxiety <input type="checkbox"/> Palpitations <input type="checkbox"/> Sores on the tip of the tongue <input type="checkbox"/> Restlessness <input type="checkbox"/> Mental confusion <input type="checkbox"/> Chest pain traveling to the shoulder <input type="checkbox"/> Frequent dreams <input type="checkbox"/> Wake un-refreshed <input type="checkbox"/> Drink coffee (# of cups/day____)
Overall Blood (Liver, Spleen, Heart) <input type="checkbox"/> Seeing floating black spots <input type="checkbox"/> Dizziness	Spleen, Stomach, Large Intestine, Small Intestine Function <input type="checkbox"/> Loose stools <input type="checkbox"/> Constipation <input type="checkbox"/> Incomplete bowel movement <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool <input type="checkbox"/> Mucous in stool <input type="checkbox"/> Undigested food in stool
Spleen Function <input type="checkbox"/> Low appetite <input type="checkbox"/> Abrupt weight gain <input type="checkbox"/> Abrupt weight loss <input type="checkbox"/> Abdominal bloating <input type="checkbox"/> Abdominal gas <input type="checkbox"/> Gurgling noise in the stomach <input type="checkbox"/> Fatigue after eating <input type="checkbox"/> Prolapsed organs (previously diagnosed/ which organs: _____) <input type="checkbox"/> Easily bruised <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Pensive <input type="checkbox"/> Over-thinking <input type="checkbox"/> Worry	Dampness Trapped in the Body <input type="checkbox"/> General sensation of heaviness in the body <input type="checkbox"/> Mental heaviness <input type="checkbox"/> Mental sluggishness <input type="checkbox"/> Mental fogginess <input type="checkbox"/> Swollen hands <input type="checkbox"/> Swollen feet <input type="checkbox"/> Swollen joints <input type="checkbox"/> Chest congestion <input type="checkbox"/> Nausea <input type="checkbox"/> Snoring

<p>Lung Function</p> <p><input type="checkbox"/> Nasal discharge</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Sinus congestion</p> <p><input type="checkbox"/> Dry mouth</p> <p><input type="checkbox"/> Dry throat</p> <p><input type="checkbox"/> Dry nose</p> <p><input type="checkbox"/> Dry skin</p> <p><input type="checkbox"/> Allergies (List: _____)</p> <p><input type="checkbox"/> Alternating fever and chills</p> <p><input type="checkbox"/> Sneezing</p> <p><input type="checkbox"/> Headache (Location: _____)</p> <p><input type="checkbox"/> Overall achy feeling in the body</p> <p><input type="checkbox"/> Stiff neck</p> <p><input type="checkbox"/> Stiff shoulders</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> Smoke cigarettes (# per day: _____)</p> <p><input type="checkbox"/> Sadness/Grief</p> <p><input type="checkbox"/> Melancholy</p>	<p>Eyes (Liver Function)</p> <p><input type="checkbox"/> Itchy</p> <p><input type="checkbox"/> Bloodshot</p> <p><input type="checkbox"/> Hot</p> <p><input type="checkbox"/> Dry</p> <p><input type="checkbox"/> Watery</p>	<p><input type="checkbox"/> Gritty</p> <p><input type="checkbox"/> Blurry vision</p> <p><input type="checkbox"/> Decreased night vision</p> <p><input type="checkbox"/> Near-sighted</p> <p><input type="checkbox"/> Far-sighted</p>
<p>Kidney, Urinary, Bladder Function</p> <p><input type="checkbox"/> Frequent cavities</p> <p><input type="checkbox"/> Easily broken bones</p> <p><input type="checkbox"/> Sore knees</p> <p><input type="checkbox"/> Weak knees</p> <p><input type="checkbox"/> Cold sensation in the knees</p> <p><input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> Memory problems</p> <p><input type="checkbox"/> Excessive hair loss</p> <p><input type="checkbox"/> Low-pitched ringing in ears</p> <p><input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Bladder infections</p> <p><input type="checkbox"/> Wake during the night twice or more to urinate</p> <p><input type="checkbox"/> Lack of bladder control</p> <p><input type="checkbox"/> Fear</p> <p><input type="checkbox"/> Easily startled</p>	<p>Urination</p> <p><input type="checkbox"/> Normal color</p> <p><input type="checkbox"/> Dark yellow</p> <p><input type="checkbox"/> Clear</p> <p><input type="checkbox"/> Reddish</p> <p><input type="checkbox"/> Cloudy</p> <p><input type="checkbox"/> Scanty</p> <p><input type="checkbox"/> Profuse</p>	<p><input type="checkbox"/> Strong odor</p> <p><input type="checkbox"/> Burning</p> <p><input type="checkbox"/> Painful</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Difficult</p> <p><input type="checkbox"/> Painful</p> <p><input type="checkbox"/> Urgent</p>
	<p>Liver, Gall Bladder Function</p> <p><input type="checkbox"/> Alternating diarrhea & constipation</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Tight sensation in the chest</p> <p><input type="checkbox"/> Bitter taste in the mouth</p> <p><input type="checkbox"/> Anger easily</p> <p><input type="checkbox"/> Frustration</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Irritability</p> <p><input type="checkbox"/> Frequently unable to adapt to stress</p> <p>What causes the stress? _____</p> <p>_____</p> <p><input type="checkbox"/> Skin rashes</p> <p><input type="checkbox"/> Headaches at the top of the head</p> <p><input type="checkbox"/> Tingling sensation</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Muscle spasms</p> <p><input type="checkbox"/> Muscle twitching</p> <p><input type="checkbox"/> Muscle cramping</p> <p><input type="checkbox"/> Seizures</p>	
	<p>Libido</p> <p><input type="checkbox"/> Normal</p> <p><input type="checkbox"/> High</p> <p><input type="checkbox"/> Low</p>	

Men Only:

swollen testes testicular pain impotence premature ejaculation
 feeling of coldness or numbness in the external genitalia

other: _____

Women Only:

Regular menstrual cycle? Y N

Pregnant? Y N

Number of children:

Number of pregnancies:

Age of first menstruation:

Age of menopause(if applicable):

Average # of days of flow:

Average # of days of entire cycle:

Vaginal discharge Y N

Bleeding between periods Y N

Please fill in the following menstrual chart:

Day	1	2	3	4	5	6	7
Color: normal, bright red, pale, brown, rust, dark, purple							
Amount of flow: normal, heavy, light							
Pain/cramps: location sharp, dull							
Clots: large, small, black, purple, red, other							
Vomiting							
Nausea							
Headache							
Other							

HIPAA

Notice of Privacy Practices

Natural Health Chiropractic Sport and Spine
4634 Camp Bowie Blvd.
Fort Worth, TX 76107

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records.

- (1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this notice of our legal duties and privacy practices with respect to that information.
- (2) We are required to abide by the terms of this notice currently in effect.
- (3) We reserve the right to change the terms of this notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this notice will be promptly displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that several people may be treated at the same time in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in our healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose our protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

- (1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
- (2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
- (3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
- (4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and address to the Privacy Officer at our address. We will respond to your request in a timely fashion.
- (5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
- (6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take on home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, <http://www.hhs.gov/ocr/hipaa>.

All questions concerning this Notice or requests made pursuant to it should be addressed to

Lynn Saul
4634 Camp Bowie Blvd.
Fort Worth, TX 76107

PRIVACY PRACTICES PATIENT ACCEPTANCE FORM

I have received or reviewed the privacy practice notice (2 pages) for Natural Health Chiropractic Sport and Spine, and understand the situation in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy practices statement.

Patient Name (Printed)

Patient Signature

Date