CONFIDENTIAL PATIENT HEALTH RECORD

SS #: _____

Today's Date: _____ Email: _____

Patient Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Sex: Male / Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Status: *(Please Circle)* Single Married Divorced Widowed

How did you hear about us? _____

Spouses Name: _____

Children *(Names & Ages)*: _____

Emergency Contact Information:

Name: _____ Phone: _____

Relationship: *(Please Circle)* Spouse Relative Friend Other: _____

Employment Information:

Business Name: _____

Business Address: _____

Business Phone #: _____

Primary Care Physician:

Name: _____ Phone: _____

Address: _____ State: _____ Zip Code: _____

Insurance Information: *(Please present your insurance card to the front desk.)*

Health Insurance Company: _____

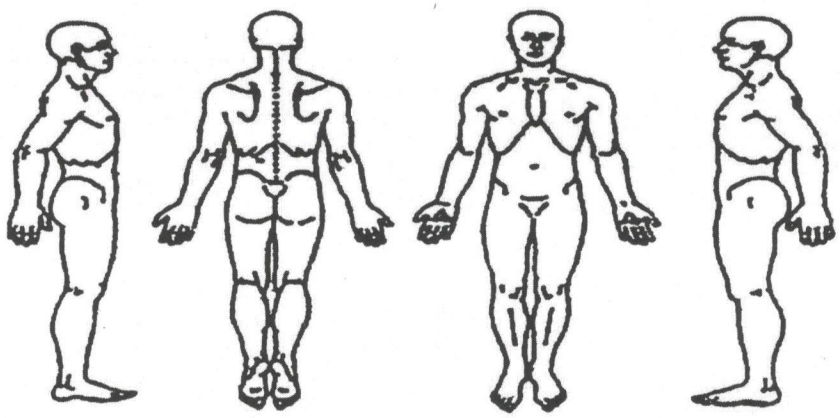
Subscriber ID #: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Relationship to Insured: _____

1. Is today's problem caused by: ☐ Auto Accident OR ☐ Workman's Compensation
2. Circle on the drawings below where you have pain/symptoms



3. Please list the pain/symptoms that you are currently experiencing
   -
   -
   -
   -
4. How often do you experience your symptoms?
   - ☐ Constantly (76–100% of the time)
   - ☐ Occasionally (26–50% of the time)
   - ☐ Frequently (51–75% of the time)
   - ☐ Intermittently (1–25% of the time)
5. How would you describe the type of pain?
   - ☐ Sharp
   - ☐ Dull
   - ☐ Diffuse
   - ☐ Achy
   - ☐ Burning
   - ☐ Shooting
   - ☐ Stiff
   - ☐ Numb
   - ☐ Tingly
   - ☐ Sharp with motion
   - ☐ Shooting with motion
   - ☐ Stabbing with motion
   - ☐ Electric like with motion
   - ☐ Other: _____
6. How are your symptoms changing with time?
   - ☐ Getting Worse ☐ Staying the Same ☐ Getting Better
7. Using a scale from 0–10 (10 being the worst), how would you rate your problem?
   0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*
8. How much has the problem interfered with your work?
   - ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
9. How much has the problem interfered with your social activities?
   - ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
10. Who else have you seen for your problem?
    - ☐ Chiropractor
    - ☐ ER Physician
    - ☐ Massage Therapist
    - ☐ Neurologist
    - ☐ Orthopedist
    - ☐ Physical Therapist
    - ☐ Primary Care Physician
    - ☐ Other: _____
    - ☐ No one

11. How long have you had this problem? _____

12. How do you think your problem began?

_____

13. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

14. What aggravates your problem? (Example: sleeping, sports, working, driving)

_____

15. What decreases or alleviates your symptoms? (Example: heat, ice, medication, resting)

_____

16. What concerns you the most about your problem; What does it prevent you from doing?

_____

17. What is your: Height _____ Weight _____ Age _____ D.O.B. _____

Occupation _____

18. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

19. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

20. Indicate if you have any immediate family member with any of the following:

☐ Rheumatiod Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

21. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee Pain	☐	☐	Abnormal Weight Gain/Loss			
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite	**For Females Only**		
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Birth Control Pills
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer	☐	☐	Pregnancy
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Hormonal Replacement
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder			
☐	☐	Cancer	☐	☐	General Fatigue			
☐	☐	Tumor	☐	☐	Muscular Incoordination			
☐	☐	Asthma	☐	☐	Visual Disturbances			
☐	☐	Chronic Sinusitis	☐	☐	Dizziness			
☐	☐	Other:						

_____

22. List all Prescription medication you are currently taking:

_____

23. List all of the over-the-counter medications you are currently taking:

_____

24. List any nutritional supplements you are currently taking:

_____

25. List all surgical procedures you have had:

_____

26. What activities do you do at work?

☐ Sit:	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ Stand:	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ Computer work:	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ On the phone:	☐ Most of the day	☐ Half the day	☐ A little of the day

27. What activities do you do outside of work? (Example: hobbies, recreation)

_____

28. Have you ever been hospitalized? ☐ No ☐ Yes
If yes, why

_____

29. Have you ever been treated by a chiropractor before? ☐ No ☐ Yes

30. Have you had significant past trauma? ☐ No ☐ Yes

31. Have you had the following routine screenings in the past 5 years? (Check all that apply):
☐ Cholesterol ☐ Prostate(Men) ☐ Pap Smear (Women) ☐ Colonoscopy

32. Anything else pertinent to your visit today?

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Saro Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Saro Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give my authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor, for x-rays, is for the examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I also agree that I am responsible for all bills incurred at this office.

Patient Name: _____

Patient Signature: _____

Date: _____

Consent to Treat a Minor: _____

Guardian Signature Authorizing Care: _____

DISCLOSURE AND CONSENT
CHIROPRACTIC CARE AND TREATMENT PLAN

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare you or alarm you: it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patent named below, for whom I am legally responsible) by Dr. Saro or those working in this office who now or in the future treat me while employed by, working or associated with, or serving as a backup for Dr. Saro.

Dr. Saro or his associate has fully explained to me:

1. The nature and purpose of the Chiropractic Treatment Plan. The Plan consists of regular chiropractic adjustments and reevaluations and, when deemed necessary, other manipulative techniques and supportive procedures.
2. The possible alternative treatments and methods, including but not limited to, foregoing any treatment: and
3. The risks and benefits to be expected under the proposed plan, as compared with possible alternative treatments and methods.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended for the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactory. By signing below, I consent to the treatment plan. 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.

Patient's Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

Dr. Steven C. Saro _____ Date _____

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Dr. Saro and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request is we have already released your health information before we receive your request to revoke your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information is they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.534).

This note is effective as of April 15, 2003. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization. I also acknowledge that I have received a copy of Saro Chiropractic Health Center's *Notice of Privacy Practices for Protected Health Information*.

Patient Name Printed	Date
Patient Signature	Authorized Provider Rep.
Personal Representative Printed	Personal Rep. Signature

Description of Personal Representative's Authority to act for the Patient