PATIENT HISTORY

Name ____ Email ____

Date of Birth _________________Age__________

Address ____

City ____ State _________________ Zip ____________________________

Phone (H) ___________________________ (W) _____________________________ (Cell) ________________________

Spouse's Name _____________________________________ Children ____

Your Occupation _________________________________ Employer ____

Insurance Company ____ Policy Number _____________________________

Have you ever received chiropractic care? Y / N Who & When?____

Who may we thank for your referral? ____

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT: ____

Date when symptom first appeared ____

Did it begin _____ Gradual _____ Sudden _____ Progressive over time

How did it occur (if applicable) ____

What makes the symptoms worse? ____

What relieves the symptoms? ____

Type of pain ____ Sharp ____Dull ____Ache ____Burn ____Throb ____Constant ____Intermittent

Does the pain radiate into your ____Arm ____Leg ____Does not radiate

Do you experience numbness or tingling? ____Y ____N

How often do you experience these symptoms? (___100% ___75% ___50% ___25% ___10%)

Severity of pain/complaint (circle 1-10) No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain

List previous treatments for this condition. Physician/other: ____

OTHER COMPLAINT(S): ____

Date when symptom first appeared ____

Did it begin _____ Gradual _____ Sudden _____ Progressive over time

How did it occur (if applicable) ____

What make the symptoms worse? ____

What relieves the symptoms? ____

Type of pain ____ Sharp ____Dull ____Ache ____Burn ____Throb ____Constant ____Intermittent

Does the pain radiate into your ____Arm ____Leg ____Does not radiate

Do you experience numbness or tingling? ____Y ____N

How often do you experience these symptoms? (___100% ___75% ___50% ___25% ___10%)

Severity of pain/complaint (circle 1-10) No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain

List previous treatments for this condition. Physician/other: ____

Additional Symptoms:

- ❑Headaches
- ❑Neck Pain
- ❑Neck Stiff
- ❑Back pain
- ❑Nervousness
- ❑Tension
- ❑Irritability
- ❑Fatigue
- ❑Depression
- ❑Face Flushed
- ❑Sleeping Problems
- ❑Pins & Needles in Legs
- ❑Pins & Needles in Arms
- ❑Numbness in Fingers
- ❑Numbness in Toes
- ❑Shortness of Breath
- ❑Chest Pains
- ❑Dizziness
- ❑Lights Bother Eyes
- ❑Loss of Memory
- ❑Ears Ring/Buzzing
- ❑Fever
- ❑Fainting
- ❑Loss of Smell
- ❑Loss of Taste
- ❑Hands Cold
- ❑Feet Cold
- ❑Diarrhea
- ❑Stomach Upset
- ❑Constipation
- ❑Cold Sweats
- ❑Loss of Balance
- ❑Allergies

Please list all past surgeries:

Type ____________________________________ When ________________________________ Doctor __________________

Type ____________________________________ When ________________________________ Doctor __________________

Type ____________________________________ When ________________________________ Doctor __________________

Type____________________________________ When ________________________________ Doctor __________________

Please list all previous accidents/falls/injuries/hospitalizations:

What ______________________________________ When _________________________________ Injuries _________________

What ______________________________________ When _________________________________ Injuries _________________

What ______________________________________ When _________________________________ Injuries _________________

What ______________________________________ When _________________________________ Injuries _________________

Please list any medications you are currently taking (include for how long and any side effects).

____

____

Current Health Behaviors:

Do you smoke/use tobacco? Y / N

Alcohol/drug use? Y / N Please explain ____

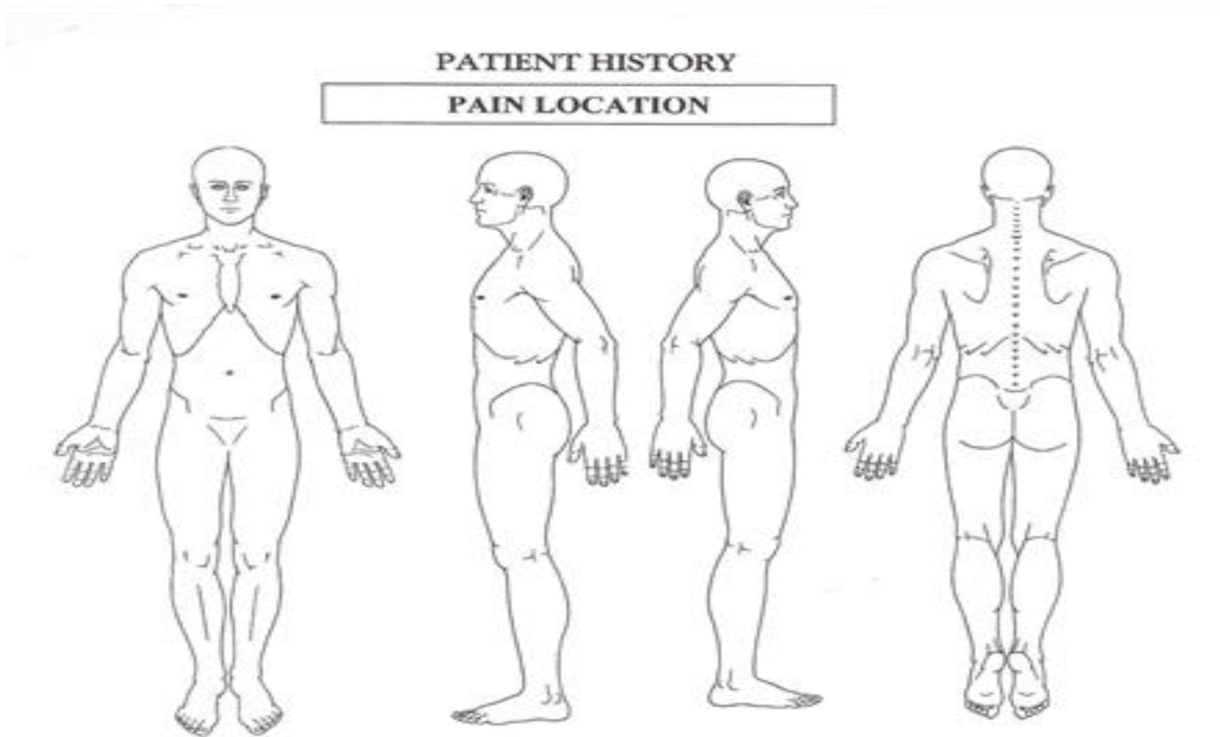
Do you exercise? Y / N What/How often?____

Do you have a healthy/nutritious diet? Y / N Please explain ____

____

What supplements do you take (if any)? ____

____



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The Nature of Chiropractic Treatment: The doctor will use his hands or a mechanical device to move your joints. You may or may not feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may or may not feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, or trigger point myotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other Treatment Options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

I have read and fully understand the above statements and accept chiropractic care on this basis.

____/____/__________________

Printed Name **Signature** **Date**

HEALTHQUEST CHIROPRACTIC & SPINE PAIN SOLUTIONS

PRIVACY NOTICE

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

In the course of your care as a patient at **HealthQuest Chiropractic Center**, all/any of its staff may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your personal health information, including your clinical records, may be disclosed to all of the doctors, interns, staff at HealthQuest.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, email, phone/fax number, and your health care records may be used to contact you regarding appointment reminders, missed appointments, information about alternatives to your present care, any correspondences from the office, or other health-related information that may be of interest to you.

You are by law, hereby granted certain rights as follows:

- the right to amend your protected health information by notifying us, and we are to comply with this within 60 days
- the right to access, inspect, and copy your protected health information (inquire about exceptions)
- the right to request restrictions on certain uses and disclosures for treatment, payment, or health care operations to which we are not required to agree.
- the right to confidential communication by alternative means or location (bearing in mind our open floor plan & atmosphere for which you consent authorization)

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written-authorization.

This notice shall serve as valid from the time you first begin care and continue for anytime thereafter. You may revoke authorization at any time by submitting request in writing to **Dr. Christopher A. Rechter at 1000 Johnson Ferry Road, Suite D100, Marietta, GA 30068.** Revocation is not possible in situations where actions have been taken relying on this authorization.
For more information or to file a complaint, contact our security and privacy officer, Dr. Christopher A. Rechter, to whom you have the right to discuss your privacy and security questions or concerns, at 770-509-3400.
You also have the right to lodge a complaint with the Department of Health and Human Services through the Office of the Patient Advocate.

A copy of this notice is/has been promptly provided to you and this signed notice will be kept as part of your file and will serve for us as an "acknowledgment of (your) receipt of a privacy notice".

HEALTHQUEST CHIROPRACTIC & SPINE PAIN SOLUTIONS

PATIENT AUTHORIZATION

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of protected health information (PHI). It is our view that the kinds of matters related in an open environment are incidental matters, in the event that you or someone else would not agree, HealthQuest is providing this disclosure.

PATIENT NAME: ____

The person identified above authorizes **HealthQuest Chiropractic Center** to use and/or disclose protected health information (PHI) in accordance with the following:

- Permission to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, email newsletters, related cards (welcome, thank you, sympathy etc) or other health related information and to leave a message on an answering device.
- Permission to adjust me in a semi-open room near where other members are also being treated. I am aware that other members in the office may overhear some of my personal healthcare information. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these communications.
- Acknowledge that **HealthQuest Chiropractic Center** utilizes a "sign in sheet" where my name can be seen by other members in the office.
- Use of your patient file by multiple **HealthQuest** staff members for the purpose of your treatment, filing of insurance, etc. and that your file may be placed on counters, wall slots and adjustment rooms where it may be seen in "incidental" contact with other people.
- Keeping of your credit card information on file (if you have requested this) and authorization to charge your card according to the terms agreed upon and applicable under the financial systems and policies in operation at HealthQuest Chiropractic Center.
- Awareness of all employees of HealthQuest including staff, interns, bookkeepers, accountants, coaches, consultants, cleaning crews or other temporary hired help being present at various times and having legal or illegal access to office property, including records (all required and appropriate protective measures are being utilized by HealthQuest).

Use of this is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effects on your care at HealthQuest Chiropractic Center or on your relationship with our staff.

Your signature indicates your authorization of all the activity outlined herein this packet.

Patient: ____ DATE____________________
(signed)

HealthQuest Representative____________________________________/__________________________________
(print) (signed)

This authorization may be revoked at any time. Revocation may be accomplished at any time by advising us (Dr. Christopher A. Rechter, privacy and security officer) in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed and be aware that revocation is not possible in situations where actions have already been taken relying on this authorization.

A copy of this authorization has been provided to you. A signed copy will be kept on file and serve as acknowledgement of your authorization.

Financial Policy

Today's charges will include consult, exam, x-rays, and your first adjustment, as well as your Report of Findings on the following visit. This fee does not include care on your return visit. Any further care must be agreed upon in writing by both parties.

We are committed to providing you with the best service possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your care at the time of service or in advance.

Health Insurance

HealthQuest is **IN NETWORK** with **Blue Cross Blue Shield and United Healthcare** insurance plans. You are responsible for any co-pays, deductibles and/or coinsurance designated by your insurance company due at the time of service. We will file your claims for you.

For all other insurances we are considered **OUT OF NETWORK**. If you have out of network insurance, we can file claims for you, however, you will be responsible for the full amount due at the time of service.

You may also choose a **self-pay** patient option and receive a discounted rate for paying at time of service or in advance. No insurance claims will be filed.

- ❑ **Health Insurance:** Please file my insurance. I have read the above information regarding network status and agree to pay the amounts due according to my insurance company status.

- ❑ **Self-Pay:** I will pay for services myself at the discounted rate at the time of service. I understand that self- pay rates are not reimbursable by insurance and no claim will be filed.

I have read and understand the above policies and have chosen the option that applies to me.

____   ____________________

Patient Signature   Date