

Confidential Patient Health Record

Today's Date: ___/___/___

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Advertisement Hospital Insurance Plan

Personal Information

Last: _____ First: _____ Middle: _____
Birth Date: ___/___/___ Age: _____ Sex: Male / Female Social Security #: _____ - _____ - _____
Marital Status: Single Married Widowed Divorced Separated
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ County: _____
Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ ext _____
Cell Phone: (_____) _____ - _____ Fax #: (_____) _____ - _____
Email Address: _____ Spouses Name: _____
Children (Names and Ages): _____

Emergency Contact

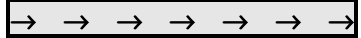
Last: _____ First: _____ Middle: _____
Relationship: Spouse Relative Friend Other _____
Phone: (_____) _____ - _____ Other: (_____) _____ - _____ ext. _____

Current Health Condition

Unwanted Condition (Why you are here today?): _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

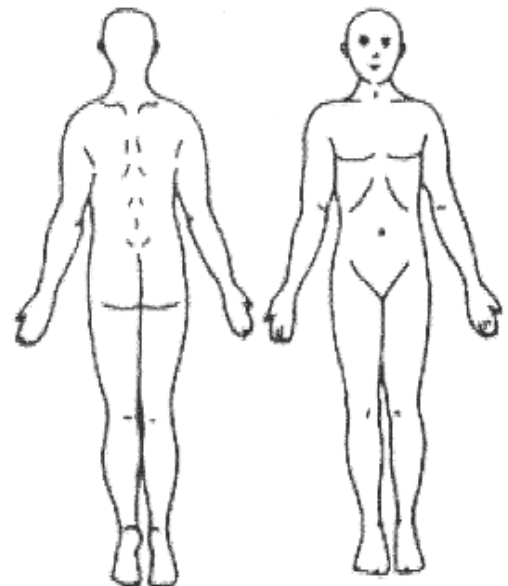
PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? ___/___/___
Has it ever occurred before? Yes No. When? _____
Is the Condition: Auto Related Job Related Home Injury
 Slip or Fall Lifting Slept Wrong Unknown Cause Other
Explain: _____

Date of Accident: _____
Time of Accident: _____ am/pm
Do you SUFFER with ANY OTHER Condition than which you are now consulting us?



Body Area(s) Involved: Cervical Spine, Ribs, Pelvis Upper Extremity Lower Extremity

Condition: New → Acute or Chronic
 Recurrence (Acute) Exacerbation (Acute) Chronic

Mechanism of Onset:

- Auto: Driver/Passenger Pedestrian (refer to completed auto accident history form)
- Work Related: Fall Falling Object Lifting Overexertion Repetitive Motion Other: _____
- Other – Liability: Slip or Fall Other: _____
- Other – No Liability: Etiology Unknown Overexertion Repetitive Use Slept Wrong Slip or Fall
- No Injury

Description of Onset of Complaint: _____

Current Symptoms: Pain Numbness Stiffness Weakness

Location: Left / Right / Bilateral _____

Quality: Burning Diffuse Dull/Aching Localized Radiating Sharp Shooting
 Stabbing Throbbing Tightness Tingling Other _____

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Duration: Started: _____

Last Occurred: _____ Last episode: _____ Resolved Previous Visit: _____

Worsened: _____ Injury Occurred: _____ Accident Occurred: _____

Timing: Worse: Morning Afternoon Night with Activity; Constant Intermittent

Context: Better with: Warm Temp Cold Temp Worse with: Warm Temp Cold Temp Damp

Assoc Signs and Symptoms: Blurred Vision Depression Dizziness Irritability/Mood Swing
 Localized Tingling Nausea Ringing in Ears Sleep Disturbance Stiffness

Headaches: Location: Occipital Frontal Left Temporal Right Temporal Parietal Sinus
Quality: Dull Sharp Throbbing Stabbing Aura No Aura
Types: Hat Band Cluster Migraine Tension
Other: (frequency/duration/time of day) _____

Radiation: Left / Right / Bilateral _____

Weakness: Left / Right / Bilateral _____

Other Assoc Signs and Symptoms: _____

Modifying Factors:

Symptoms Better With: nothing helps activity bending applying cold applying heat
 massage movement OTC meds Rx meds rest
 stretching sitting standing twisting walking

Symptoms Worse With: (as noted in Social History)

Since condition began, has anything permanently helped you? YES NO

Has anything that you have done, thus far, fixed your problem? YES NO

Employment:

Occupation/Job Title: _____ Work: _____ hrs / day or week

Description of Work: _____

Condition's Effect On Job Performance:

Mild Painful (Can do) **Mod** Painful (limited ability) **Mod/Sev** Limited Duty **Sev** No Limited Duty **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Care –Infirm Family:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Carrying Groceries:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Change Posn–Sit-Stand:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Climb Stairs:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Driving:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Extended Computer Use:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Feeding:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Household Chores:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Kneeling:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Lift Children:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Lifting:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Pet Care:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Reading (Concentration):	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Self Care:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Self Care–Bathing:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Self Care–Dressing:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Self Care–Shaving:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Sexual Activities:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Sleep:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Sitting:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Standing:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Walking:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Yard Work:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
_____	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

Name	Dosage	For What Condition, if any?	How long have you been taking this?

Injury (ies): List All Injuries. Write the DATE of the Injury immediately afterward.

Non-Drug Allergies: Please list any known non-drug allergies below.

Adult Illness (es): LIST all health conditions.

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional (General): I DENY having or have had any of the symptoms or problems listed below.

chills fever fatigue weight loss weight gain daytime drowsiness night sweats

Eyes/Vision: I DENY having any of the symptoms or problems listed below.

blindness eye pain change in vision field cuts photophobia itching
 blurred vision double vision glaucoma tearing cataracts

Ears, Nose and Throat: I DENY having any of the symptoms or problems listed below.

bleeding nasal congestion hearing loss nosebleeds sore throat
 dentures ear pain ear drainage history of head injury postnasal drip tinnitus
 difficulty swallowing fainting headaches hoarseness snoring rhinorrhea TMJ problems
 discharge frequent sore throats loss of sense of smell sinus infections dizziness

Respiration: I DENY having any of the symptoms or problems listed below.

asthma coughing up blood shortness of breath wheezing

Cardiovascular: I DENY having any of the symptoms or problems listed below.

angina (chest pain or discomfort) shortness of breath with exertion or exercise heart problems
 paroxysmal nocturnal dyspnea low blood pressure high blood pressure swelling of legs
 claudication (leg pain/ache) orthopnea (difficulty breathing lying down) ulcers varicose veins
 heart murmur palpitations

Gastrointestinal: I DENY having any of the symptoms or problems listed below.

abdominal pain diarrhea nausea indigestion abnormal stool caliber vomiting blood
 vomiting jaundice abnormal stool color hemorrhoids difficulty swallowing constipation

Endocrine: I DENY having any of the symptoms or problems listed below.

cold intolerance excessive hunger excessive thirst goiter diabetes unusual hair growth
 heat intolerance abnormal frequency of urination hair loss voice changes

Skin: I DENY having any of the symptoms or problems listed below.

changes in nail texture hair loss hair growth history of skin disorders skin lesions / ulcers
 changes in skin color hives itching rash paresthesias varicosities



**BROADVIEW BACK & NECK CLINIC
WEIGHT LOSS 4 LIFE CLINIC
203 E. ROYALTON RD. #108
BROADVIEW HTS. OH 44147**



Phone: (440) 526-4940 Fax: (440) 526-4885

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows:

NAME: Lissa Molchan
ADDRESS: 203 E. Royalton Road #108
Broadview Heights OH 44147
PHONE: (440)526-4940

PRACTICE'S REQUIREMENTS

The Practice is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

- a) Under the Privacy Rule, may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided under federal law.
- b) Is required to abide by the terms of this Privacy Notice.
- c) Reserves the reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
- d) Will distribute any revised Privacy Notice to you prior to implementation.
- e) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This notice is in effect as of April 15, 2003.

Patient Signature _____

Date _____

Staff Initial _____

POLICIES FOR PATIENTS

To help you receive our best, all patients are accepted for care based on the following policies:

- ❑ **Appointment Scheduling:** To save you time on each visit we ask that you pre-schedule your appointments in advance and that you refrain from repeatedly rescheduling

appointments. In order to keep your progress on schedule, rescheduled appointments should be made up within 48 hours of the original scheduled time.

- ❑ **Broken Appointments:** There is a \$10 fee for a missed or forgotten appointment. To keep your progress on schedule, missed appointments should be made up within 48 hours. If you repeatedly miss or reschedule appointments or we must continually call you to reschedule, we will regretfully need to discharge you from our care.

- ❑ **Children/Family:** Once you understand the nervous system controls the function of your body and that subluxations interfere with the nervous energy flow, we expect that you would want everyone in your family to be checked for subluxations. We do have a family cost effective program for you. Please make sure your family and loved ones are checked for subluxations!

- ❑ **Financial Agreements:** It is your payment that allows us to continue providing high levels of professional care, maintain our facility and pay our staff. If for any reason you cannot keep your financial agreement, please inform us immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements. Balance in full must be paid upon dismissal unless other arrangements have been made. A 5% service charge will be added monthly to any unpaid balance.

Patient Name Printed _____

Patient Signature _____ Date _____