HealthGoals
Chiropractic Center

Confidential Patient Health Record

Date:____/____/_____

Personal History

First:_____ Middle:____ Last: _____ Gender: Male / Female
Address: _____Apt # _____
City: _____ State: _____ Zip: _____ County: _____ Country: _____
Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____
Social Security #: _____-_____-_____ Birth Date: ____/____/_____ Age:_____
Email Address: _____ Sign up for our Email Newsletter? YES NO

Employer

Business Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: (_____)_____-_____ Type of Work:_____

Circle One: Divorced Married Single Separated Widowed
Spouses Name: _____ Spouses Employer:_____
Spouses Occupation: _____ Work Phone# : _____
Ages of Children: _____

How were you referred to our office? _____

Emergency Contact

Name: _____ Phone Number: (_____)_____-_____
Address: _____
Relationship:_____

Who Is Responsible For Your Bill?
☐ Self ☐ Health Insurance ☐ Work. Comp ☐ Auto Ins. ☐ Medicare ☐ Other (be specific):_____
Insurance Carrier: _____ ID #: _____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ Primary Care Physician: _____
Insured Person's Social Security #: _____-_____-_____

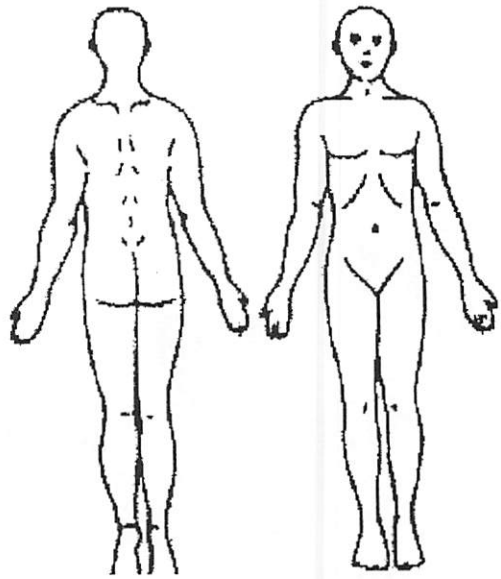
CURRENT HEALTH CONDITION

Chief complaint (Why you are here today):_____
_____
_____

Use the letters below to indicate the type and location of you sensations right now:
A= Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →



--When did this complaint/condition begin? _____
--Has it ever occurred before? ☐ Yes ☐ No
If so, When? _____
--Is the condition: ☐ Auto Related ☐ Work Related
☐ No Injury ☐ Other
Explain: _____
_____
--Does your pain radiate? ☐ Yes ☐ No
If yes, describe: _____
--Have you lost time from work? _____

--Please Rate Your Symptoms on a Pain Scale (Zero=No pain) (10=Worst Pain):

RESTING:	0	1	2	3	4	5	6	7	8	9	10
ACTIVE:	0	1	2	3	4	5	6	7	8	9	10

Have you seen other doctors for this condition? ☐ Yes ☐ No If yes, Who? (Name) _____
Location of Office: _____ Type of Treatment: _____
Were you satisfied with the results of your treatment? ☐ Yes ☐ No Explain: _____
Are you currently taking any prescription medications? ☐ Yes ☐ No. If yes, please mark or list below (be specific).
☐ Allergy Medication ☐ Anti-Depressants ☐ Blood Pressure Medication ☐ Insulin ☐ Muscle Relaxers
☐ Nerve Pills ☐ Pain Killers ☐ Other (please be specific): _____

Do you wear any of the following? ☐Yes ☐ No. If yes, please mark: ☐ Heel Lifts ☐ Innersoles ☐ Arch Supports ☐ Orthotics

Please list any other conditions you feel we should know about – even if unrelated: _____

What is your goal for care at our office? What would you like to be able to do better and/or easier than you are doing right now?

Please Specify the Effect of your Current Condition on the following Daily Activities:

Caring for 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
Ext Computer Use:	☐	No Effect	☐	Mild	Painful (Can do)	☐	Mod	Painful (Limited)	☐	Sev	Unable to Perform
Feeding Yourself:	☐	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
Lift Children:	☐	No Effect	☐	Mild	Painful (Can do)	☐	Mod	Painful (Limited)	☐	Sev	Unable to Perform
Lifting (Generalized):	☐	No Effect	☐	Mild	Painful (Can do)	☐	Mod	Painful (Limited)	☐	Sev	Unable to Perform
Daily 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–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
Static Sitting:	☐	No Effect	☐	Mild	Painful (Can do)	☐	Mod	Painful (Limited)	☐	Sev	Unable to Perform
Static 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

Please Specify the Effect of your Current Condition on your Recreational Activities:

_____	☐	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
_____	☐	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

REVIEW OF SYSTEMS--Below is a list of diseases 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.

– Please fill out all of the sections, even if "DENY".

Constitutional: I... ☐ Deny Any Constitutional Issue (s) (Pertaining to the Body as a Whole)

☐ Chills ☐ Daytime Somnolence (Drowsiness) ☐ Fatigue ☐ Fever ☐ Night Sweats
☐ Weight Gain ☐ Weight Loss

Eyes/Vision: I... ☐ Deny Any Eyes/Vision Issue (s)

☐ Blindness ☐ Blurred Vision ☐ Cataracts ☐ Change in vision ☐ Double Vision
☐ Eye Pain ☐ Field Cuts (visual field defect) ☐ Glaucoma ☐ Itching (around the eyes) ☐ Photophobia
☐ Tearing ☐ Wears Glasses and/or Contact lenses

Ears, Nose and Throat: I... ☐ Deny Any Ears, Nose and Throat Issue (s)

☐ Bleeding ☐ Dental Implants ☐ Dentures ☐ Difficulty Swallowing ☐ Discharge
☐ Dizziness ☐ Ear Drainage ☐ Ear Infection(s) ☐ Ear Pain ☐ Fainting
☐ Headaches ☐ Head Injury (history of) ☐ Hearing Loss ☐ Hoarseness ☐ Loss of Smell
☐ Nasal Congestion ☐ Nose bleeds (frequent) ☐ Post Nasal Drip ☐ Rhinorrhea (Runny nose) ☐ Sinus Infections
☐ Snoring ☐ Sore Throats (frequent) ☐ Tinnitus (Ringing in Ears) ☐ TMJ problems

Respiration: I... ☐ Deny Any Respiratory Issue (s)

☐ Asthma ☐ Cough ☐ Coughing up blood ☐ Shortness of Breath ☐ Sputum Production ☐ Wheezing

Cardiovascular: I... ☐ Deny Any Cardiovascular Issue (s)

☐ Angina (chest pain or discomfort) ☐ Chest Pain ☐ Claudication (leg pain or achiness) ☐ Heart Murmor
☐ Heart Problems ☐ Orthopnea (difficulty breathing while lying down) ☐ Palpitations (irregular or forceful beating of the heart)
☐ Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath) ☐ Shortness of Breath with Exertion or Exercise
☐ Swelling of Legs ☐ Ulcers ☐ Varicose Veins

Gastrointestinal: I... ☐ Deny Any Gastrointestinal Issue (s)

☐ Abdominal Pain ☐ Belching ☐ Black, Tarry Stools ☐ Constipation ☐ Diarrhea
☐ Difficulty Swallowing ☐ Heartburn ☐ Hemorrhoids ☐ Indigestion ☐ Jaundice (yellowing of the skin)
☐ Nausea ☐ Rectal Bleeding ☐ Abnormal Stool Caliber (quality) ☐ Abnormal Stool Color
☐ Abnormal Stool Consistency ☐ Vomiting ☐ Vomiting Blood

Female: I... ☐ Deny Any Female Issue (s)

☐ Birth Control Therapy ☐ Breast Lumps/Pain ☐ Burning Urination ☐ Cramps ☐ Frequent Urination
☐ Hormone Therapy ☐ Irregular Menstruation ☐ Urine Retention ☐ Vaginal Bleeding ☐ Vaginal Discharge

Male: I... ☐ Deny Any Male Issue (s)

☐ Burning Urination ☐ Erectile Dysfunction ☐ Frequent Urination ☐ Hesitancy/Dribbling ☐ Prostate Problems
☐ Urine Retention

Endocrine: I... ☐ Deny Any Endocrine Issue (s)

☐ Cold Intolerance ☐ Diabetes ☐ Excessive Appetite ☐ Excessive Hunger ☐ Excessive Thirst
☐ Frequent Urination ☐ Goiter ☐ Hair Loss ☐ Heat Intolerance ☐ Unusual Hair Growth
☐ Voice Changes

Skin: I... ☐ Deny Any Skin Issue (s)

☐ Changes in Nail Texture ☐ Changes in Skin Color ☐ Hair Growth ☐ Hair Loss ☐ Hives ☐ Itching
☐ Paresthesia (numbness, prickling, or tingling) ☐ Rash ☐ History of Skin Disorders ☐ Skin Lesions/Ulcers ☐ Varicosities

Nervous System: I... ☐ Deny Any Nervous System Issue (s)

☐ Dizziness ☐ Facial Weakness ☐ Headaches ☐ Limb Weakness ☐ Loss of Consciousness
☐ Loss of Memory ☐ Numbness ☐ Seizures ☐ Sleep Disturbance ☐ Slurred Speech
☐ Stress ☐ Strokes ☐ Tremors ☐ Unsteadiness of Gait

Psychologic: I... ☐ Deny Any Psychologic Issue (s)

☐ Anhedonia (inability to experience joy or enjoy life) ☐ Anxiety ☐ Appetite Changes ☐ Behavioral Change(s)
☐ Bipolar Disorder ☐ Confusion ☐ Convulsions ☐ Depression ☐ Insomnia ☐ Memory Loss
☐ Mood Change(s)

Allergy: I... ☐ Deny Any Allergy Issue (s)
☐ Anaphylaxis (history of) ☐ Food Intolerance ☐ Itching ☐ Nasal Congestion ☐ Sneezing

Hematology: I... ☐ Deny Any Hematologic Issue (s)
☐ Anemia ☐ Bleeding ☐ Blood Clotting ☐ Blood Transfusion(s) ☐ Bruises easily ☐ Fatigue ☐ Lymph Node Swelling

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

Childhood Illness: I... ☐ Deny Any Childhood Illness (es)

☐ ADD	☐ Allergies/Hayfever	☐ Asthma	☐ Atopic Dermatitis (Eczema)	☐ Bedwetting
☐ Cerebral Palsy	☐ Chicken Pox	☐ Depression	☐ Diabetes	☐ Ear Infections
☐ Fetal Drug Exposure	☐ Food Allergies	☐ Headaches	☐ Hepatitis	☐ HIV
☐ Measles	☐ Mumps	☐ Rash	☐ Scoliosis	☐ Seizure Disorder
☐ Sickle Cell Anemia	☐ Spina Bifida	☐ Other (please describe): _____		

Adult Illness: I... ☐ Deny Any Adult Illness (es)

☐ Alzheimers	☐ Anemia	☐ Arthritis	☐ Asthma	☐ Cancer
☐ Chicken Pox	☐ Crohn's/Colitis	☐ CRPS (RSD)	☐ CVA (stroke)	☐ Cystic Kidney Disease
☐ Depression	☐ Diabetes (Insulin)	☐ Diabetes (Non insulin)	☐ Ear Infections (frequent)	☐ Emphysema
☐ E ye Problems	☐ Fibromyalgia	☐ Heart Disease	☐ Hepatitis	☐ HIV
☐ Hypertension	☐ Influenzal Pneumonia	☐ Liver Disease	☐ Lung Disease	☐ Lupus Erythema (discoid)
☐ Lupus Erythema (systemic)	☐ Multiple Sclerosis	☐ Parkinson's Disease	☐ Pleurisy	☐ Pneumonia
☐ Psychiatric Problems	☐ Scoliosis	☐ Seizure Disorder	☐ Shingles	☐ STD's (unspecified)
☐ Suicide Attempt(s)	☐ Thyroid Problems	☐ Vertigo		

☐ Past history of similar symptoms to your current condition ☐ Other Illness (please be specific): _____

Surgeries: I... ☐ Deny Any Surgery (ies)

☐ Angioplasty	☐ Appendectomy	☐ Caesarian Section	☐ Cardiac Catheterization	☐ Carpal Tunnel Repair
☐ Coronary Artery Bypass	☐ Cosmetic	☐ D & C	☐ Dental Surgery	☐ Gallbladder
☐ Hemorrhoidectomy	☐ Hernia Repair	☐ Hysterectomy	☐ Joint Reconstruction	☐ Joint Replacement
☐ Laminectomy	☐ Mastectomy	☐ Pacemaker Insertion	☐ Rotator Cuff	☐ Spinal Fusion
☐ Tonsilectomy	☐ Other (please be specific): _____			

Ob/Gyn: I... ☐ Deny Any Ob/Gyn Issue (s)
I... ☐ have never been pregnant ☐ have been pregnant in the past ☐ am currently pregnant
_____ Number of pregnancies _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies
_____ Number of miscarriages _____ Number of terminated pregnancies _____ Number of Epidural Injections
_____ Number of C-Sections _____ Number of vaginal deliveries

Menstrual History: Age of Onset _____
My menses is ☐ Regular ☐ Irregular; I am currently in ☐ Metaphase ☐ Menopause; Date of Last Menses _____/_____/_____

Injuries: I... ☐ Deny Any Injury (ies)

☐ Back Injury	☐ Broken Bones	☐ Severe Fall	☐ Fracture	☐ Disability
☐ Head Injury	☐ Industrial Accident	☐ Joint Injury	☐ Severe Laceration	☐ Motor Vehicle Accident
☐ Mild/Moderate Soft Tissue Injury		☐ Severe Soft Tissue Injury		

Immunizations: I... ☐ Deny Any Immunization (s)
☐ DTaP(diptheria, tetanus, and pertussis) ☐ Flu ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
☐ Influenza ☐ IPV (Polio) ☐ MMR (measles, mumps, and rubella) ☐ Pneumococcal
☐ PPD (Mantoux Test-TB) ☐ Small Pox ☐ TB ☐ Varivax (chicken pox) ☐ Whooping Cough (Pertussis)

Non-Drug Allergies: I... ☐ Deny Any Non-Drug Allergy (ies)
☐ Animals ☐ Dairy ☐ Eggs ☐ Food Coloring ☐ Mold ☐ Pollen ☐ Wheat
☐ Other (please be specific): _____
Type of Reaction: ☐ Swelling ☐ Anaphylaxis ☐ GI Disturbance ☐ Headache ☐ Joint Pain ☐ Rash ☐ Shortness of Breath
☐ Other: _____

FAMILY HISTORY

Condition (Please be specific)

General Family	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Father	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Mother	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Paternal Grandfather	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Paternal Grandmother	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Maternal Grandfather	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Maternal Grandmother	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Son (s)	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Daughter (s)	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Brother (s)	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Sister (s)	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____

SOCIAL HISTORY

Alcohol: ☐ Never ☐ Social Consumption only ☐ Beer ☐ Liquor ☐ Wine ; _____ oz ____ glasses; ☐ Day ☐ Week ☐ Month

Diet (Please mark all that apply): ☐ High Fat ☐ High Fiber ☐ High Protein ☐ High Salt ☐ Low Calorie ☐ Low Carb ☐ Low Fiber ☐ Low Salt ☐ Low Sugar

Education (Please mark the highest level completed): ☐ Preschool ☐ Elementary ☐ Middle ☐ Junior High ☐ Votech ☐ In High School ☐ Did Not Finish High School ☐ High School Diploma ☐ Post High School Classes ☐ Assoc/Technical Degree ☐ In College ☐ College Degree ☐ In Graduate School ☐ Graduate Degree ☐ Doctorate ☐ Other: _____

Drugs: ☐ Deny any illegal drug use ☐ Deny use of IV drugs ☐ Have not used drugs since _____ ☐ Have used drugs for _____

Tobacco: ☐ Deny Tobacco Use ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker ☐ Quit smoking ☐ Smoke; # _____ per ☐ Day ☐ Week ☐ Month ☐ Chew; #_____cans per ☐ Day ☐ Week ☐ Year

HealthGoals
Chiropractic Center

Authorization/Informed Consent

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature_____

Health Symptoms Questionnaire

Name: _____ Date: _____

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely have the symptom
1 Occasionally have it, effect is not severe
2 Occasionally have it, effect is severe
3 Frequently have it, effect is not severe
4 Frequently have it, effect is severe

Digestive tract	Nausea, vomiting	⓪ ① ② ③ ④	
	Diarrhea	⓪ ① ② ③ ④	
	Constipation	⓪ ① ② ③ ④	
	Bloated feeling	⓪ ① ② ③ ④	
	Heartburn	⓪ ① ② ③ ④	
	Intestinal, stomach pain	⓪ ① ② ③ ④	
	Digestive total:		0
Joints/muscles	Pain or aches in joints	⓪ ① ② ③ ④	
	Arthritis, joint swelling	⓪ ① ② ③ ④	
	Stiff or limitation of movement	⓪ ① ② ③ ④	
	Pain or aches in muscles	⓪ ① ② ③ ④	
	Feeling of weakness or tired	⓪ ① ② ③ ④	
	Joints/muscles total:		0
Emotional	Mood swings	⓪ ① ② ③ ④	
	Anxiety, fear, nervousness	⓪ ① ② ③ ④	
	Anger, irritability, aggression	⓪ ① ② ③ ④	
	Depression	⓪ ① ② ③ ④	
	Emotional total:		0
Weight/food	Binge eating, drinking	⓪ ① ② ③ ④	
	Craving certain foods	⓪ ① ② ③ ④	
	Excessive weight	⓪ ① ② ③ ④	
	Compulsive eating, food addictions	⓪ ① ② ③ ④	
	Water retention	⓪ ① ② ③ ④	
	Underweight	⓪ ① ② ③ ④	
	Weight/food total:		0
Energy/sleep	Fatigue, sluggishness	⓪ ① ② ③ ④	
	Apathy, lethargy	⓪ ① ② ③ ④	
	Hyperactivity	⓪ ① ② ③ ④	
	Restlessness, achiness	⓪ ① ② ③ ④	
	Sleep disturbances	⓪ ① ② ③ ④	
	Energy/sleep total:		0
Skin	Acne	⓪ ① ② ③ ④	
	Hives, rashes, dry skin, redness	⓪ ① ② ③ ④	
	Hair loss	⓪ ① ② ③ ④	
	Flushing, hot flashes	⓪ ① ② ③ ④	
	Excessive sweating	⓪ ① ② ③ ④	
	Skin total:		0
Heart	Irregular or skipped heartbeat	⓪ ① ② ③ ④	
	Rapid or pounding heartbeat	⓪ ① ② ③ ④	
	Chest pain	⓪ ① ② ③ ④	
	Heart total:		0
Other	Frequent illness	⓪ ① ② ③ ④	
	Frequent or urgent urination	⓪ ① ② ③ ④	
	Genital itch or discharge	⓪ ① ② ③ ④	
	Other total:		0

Respiratory	Chest congestion	⓪ ① ② ③ ④	
	Asthma, bronchitis	⓪ ① ② ③ ④	
	Shortness of breath	⓪ ① ② ③ ④	
	Difficulty breathing	⓪ ① ② ③ ④	
	Respiratory total:		0
Eyes	Watery or itchy eyes	⓪ ① ② ③ ④	
	Swollen, red, or sticky eyelids	⓪ ① ② ③ ④	
	Bags or dark circles under eyes	⓪ ① ② ③ ④	
	Blurred or restricted vision	⓪ ① ② ③ ④	
	Eyes total:		0
Nose	Stuffy nose	⓪ ① ② ③ ④	
	Sinus problems or dripping nose	⓪ ① ② ③ ④	
	Hay fever	⓪ ① ② ③ ④	
	Sneezing attacks	⓪ ① ② ③ ④	
	Excessive mucus	⓪ ① ② ③ ④	
	Nose total:		0
Mouth/throat	Frequent, consistent coughing	⓪ ① ② ③ ④	
	Gagging, need to clear throat	⓪ ① ② ③ ④	
	Sore throat, hoarse, loss of voice	⓪ ① ② ③ ④	
	Swollen or discolored tongue, gums, or lips	⓪ ① ② ③ ④	
	Canker sores, other mouth sores	⓪ ① ② ③ ④	
	Mouth/throat total:		0
Ears	Itchy ears	⓪ ① ② ③ ④	
	Earaches, ear infections	⓪ ① ② ③ ④	
	Drainage from ear, waxy buildup	⓪ ① ② ③ ④	
	Ringing in ears, hearing loss	⓪ ① ② ③ ④	
	Ears total:		0
Head	Headaches	⓪ ① ② ③ ④	
	Faintness or lightheadedness	⓪ ① ② ③ ④	
	Dizziness	⓪ ① ② ③ ④	
	Head total:		0
Cognitive	Poor memory, recall	⓪ ① ② ③ ④	
	Confusion, poor comprehension	⓪ ① ② ③ ④	
	Poor concentration	⓪ ① ② ③ ④	
	Poor physical coordination	⓪ ① ② ③ ④	
	Difficulty making decisions	⓪ ① ② ③ ④	
	Stuttering, stammering	⓪ ① ② ③ ④	
	Slurred speech	⓪ ① ② ③ ④	
	Learning disabilities	⓪ ① ② ③ ④	
	Cognitive total:		0

Grand total 0

FirstLine Therapy®
Lifestyle Medicine Programs by Metagenics

PATIENT FINANCIAL AGREEMENT & ACKNOWLEDGEMENT OF OFFICE POLICIES

Health Goals Chiropractic believes that part of good health care practice is to communicate our office and financial policy to our patients. We provide the best possible care for you, and we want you to have a full understanding of our policies.

1. PAYMENT is expected at the time of your visit. We accept cash, check, Visa, and Mastercard. Payment will include any unmet deductible, co-insurance, co-payment amount, charges not covered by your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit. All non-filed services are expected to be paid at the time of service.

2. INSURANCE: We are participating providers with many insurance plans. We will file all the claims for these plans. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. As a courtesy to our patients, we will verify your insurance coverage, however, our verification is not a guarantee of benefits payable by your insurance. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral for your visit in our office to be covered under your medical insurance.** If our providers are out of network in your plan, you may be responsible for partial or full payment.

3. POLICY ON NON-COVERED SERVICES: This office offers access to many innovative services and procedures some of them are deemed as "not covered" by insurance. You will be responsible for payment in full at the time of service for these procedures.

4. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Health Goals Chiropractic for charges not covered by the assignment of insurance benefits and all non-covered charges.

5. AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Health Goals Chiropractic to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Health Goals Chiropractic all payments otherwise payable to me for professional services.

6. CONSENT AND DISCLOSURES: I voluntarily consent to medical treatment for myself and/or my dependents.

7. RELEASE OF INFORMATION: I hereby authorize and direct Health Goals Chiropractic to release (verbally or in writing) confidential medical information to any person, entity, government agencies, insurance carriers, or others who are financially liable to Health Goals Chiropractic for charges for medical treatment, and for quality management, utilization review, transfer of medical care, and follow up purposes. I understand that a copy of this document may be used with the same effectiveness as an original.

8. NO SHOW POLICY: We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide at least 24-hour notice. Patients who do not show up nor provide more than a 24-hour notice are considered a NO SHOW. **Patients who No-Show two (2) or more times will be asked to keep a credit card on file and with be charged $25 for all future No-Shows.**

I have read and understand the practice's office and financial policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

Signature of Patient/Guarantor Date

HEALTH GOALS CHIROPRACTIC CENTER, INC.

NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy 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 PHI. "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 condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment: We may use and disclose your personal information to provide you with treatment or services. For example, we may use your health information to prescribe a course of treatment or make a referral. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.

Payment: We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

Health Care Operations: We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

Other Permitted and Required Uses and Disclosure will be made **only** with your consent, authorization or opportunity to object unless required by law. You may revoke the 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 HEALTH INFORMATION RIGHTS

The following are statements of your rights with respect to your protected health information.

Right to Obtain a Paper Copy of This Notice: You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. You have a right to information that is stored electronically that is not in EHR software, including information stored in MS Word, Excel, PDF, plain text and other electronic formats. To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your **medical information, we may** charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record. You have a right to have this information with-in 30 days of receipt of your request.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information. To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for [name of provider];
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by email). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. You have a right to restrict certain disclosures of Protected Health Information to a health plan where you have paid out of pocket in full for the healthcare item or service. As noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure, or both and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable requests.

Right to Receive Notice of a Breach: We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.** To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

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 protect health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

By signing this Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature: _____ Date_____

Print Name: _____

Privacy & Security Officer – Colleen Pangretic
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856-983-5422

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