# Huntsville Chiropractic Clinic

## Dr. David Land

## Confidential Patient Case History

Date _____

Name _____ Home Phone_____ Cell Phone_____

Address _____ City _____ State_____ Zip _____

Age ____ Birth Date _____ Sex M F Marital Status M S W D Number of Children _____ SS#_____

Employer _____ Occupation _____ e-mail _____

Work Address _____ Work Phone _____

Name of Spouse _____Spouse's Work Phone _____

In Case of Emergency, please notify _____ Phone _____

How did you hear about our office? Friend _____ □ Phonebook □ Employer □ Internet □ Other

Please list complaints and date the condition started, starting with your major complaint.

| Complaints | Date Started |
|---|---|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |
| 4. _____ | 4. _____ |

Is your condition getting worse? □ Yes □ No Is it Constant? □ Yes □ No Comes and Goes? □ Yes □ No
Have you seen other doctors for this condition? □ Yes □ No

Please list other doctors seen and approximate date seen (including primary care physician):

| Doctor | Approximate Date Seen |
|---|---|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |

Have you experienced any serious accidents or falls within the □ Past year? □ 5 years? □ Over 5 years □ Never

If you have experienced an accident, what type was it? □ Auto □ Work □ Home □ Leisure □ Sports □ Other _____

Briefly Explain: _____

Are you presently taking any medication? □ Yes □ No Please List _____

List Surgical procedures you have had and an approximate date.

| Procedure | Date |
|---|---|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |

Has any blood relative ever had:

| | Who | | Who |
|---|---|---|---|
| Cancer | _____ | Stroke | _____ |
| Diabetes | _____ | Arteriosclerosis | _____ |
| Heart Trouble | _____ | Arthritis | _____ |
| High Blood Pressure | _____ | Spinal Curvature | _____ |

Check the following that you have had:

| | | | | |
|---|---|---|---|---|
| □ Alcoholism | □ Chorea | □ Gout | □ Multiple Sclerosis | □ Stroke |
| □ Anemia | □ Cold Sores | □ Heart Disease | □ Mumps | □ Tuberculosis |
| □ Appendicitis | □ Diabetes | □ Influenza | □ Pleurisy | □ Typhoid Fever |
| □ Arteriosclerosis | □ Diptheria | □ Lumbago | □ Pneumonia | □ Ulcers |
| □ Arthritis | □ Eczema | □ Measles | □ Polio | □ Whooping Cough |
| □ Asthma | □ Emphysema | □ Migraines | □ Rheumatic Fever | |
| □ Cancer | □ Epilepsy | □ Miscarriage | □ Scarlet Fever | |

Check the following symptoms you have had within the past year:

**General**
- □ Allergy
- □ Chills
- □ Convulsions
- □ Dizziness
- □ Fainting
- □ Fatigue
- □ Fever
- □ Headache
- □ Loss of Sleep
- □ Loss of weight
- □ Depression
- □ Neuralgia
- □ Sweats
- □ Tremors

**Cardiovascular**
- □ Chest pain
- □ Angina
- □ ↑ blood pressure
- □ Low blood pressure
- □ Poor circulation
- □ Rapid Heart beat
- □ Slow heart beat
- □ Ankle swelling

**Muscle & Joint**
- □ Arthritis
- □ Bursitis
- □ Foot trouble
- □ Hernia
- □ Low back pain
- □ Lumbago
- □ Neck Pain
- □ Shoulder Pain

Pain or numbness in:
- □ Shoulders
- □ Arms
- □ Elbows
- □ Hands
- □ Hips
- □ Legs
- □ Knees
- □ Feet
- □ Tailbone

- □ Poor Posture
- □ Sciatica
- □ Spinal Curvature
- □ Swollen joints

**Eyes, Ears, & Nose**
- □ Asthma
- □ Colds
- □ Crossed Eyes
- □ Deafness
- □ Dental Decay
- □ Ear Ache
- □ Ear Discharge
- □ Ear Noises
- □ Enlarged glands
- □ Enlarged thyroid
- □ Eye pain
- □ Failing vision
- □ Far sightedness
- □ Gum trouble
- □ Hay fever
- □ Hoarseness
- □ Nasal obstruction
- □ Near sightedness
- □ Nosebleeds
- □ Sinus Infection
- □ Sore throat
- □ Tonsillitis

**Respiratory**
- □ Chest pain
- □ Chronic cough
- □ Difficulty breathing
- □ Spitting up blood
- □ Spitting up phlegm
- □ Wheezing

**Gastro-intestinal**
- □ Belching or gas
- □ Crohn's disease
- □ Colitis
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficult Digestion
- □ Gall Bladder trouble
- □ Hemorrhoids
- □ Jaundice
- □ Liver trouble
- □ Nausea
- □ Stomach pain
- □ Poor appetite
- □ Vomiting
- □ Rectal pain

**Skin**
- □ Bruise easily
- □ Dryness
- □ Hives or allergy
- □ Itching
- □ Rashes
- □ Varicose Veins

**Genito-urinary**
- □ Bed wetting
- □ Blood in urine
- □ Frequent urination
- □ Bladder control
- □ Kidney infection
- □ Painful urination
- □ Prostate trouble

**Women Only**
- □ Cramps
- □ Excessive flow
- □ Hot Flashes
- □ Irregular cycles
- □ Menopause
- □ Painful Flow
- □ Vaginal Discharge

| | Yes | No |
|---|---|---|
| Have you ever been knocked unconscious? | □ | □ |
| Do you use a cane or other support? | □ | □ |
| Have you been treated for a spine or nerve disorder? | □ | □ |
| Have you ever had a fractured bone? | □ | □ |
| Have you been hospitalized for anything other than surgery? | □ | □ |
| Do you smoke? | □ | □ |
| Do you now take vitamins or minerals? | □ | □ |

**Habits:**

| | Heavy | Moderate | Light | None |
|---|---|---|---|---|
| Alcohol | □ | □ | □ | □ |
| Coffee | □ | □ | □ | □ |
| Tobacco | □ | □ | □ | □ |
| Drugs | □ | □ | □ | □ |
| Exercise | □ | □ | □ | □ |
| Sleep | □ | □ | □ | □ |
| Appetite | □ | □ | □ | □ |

**Date of Last:**

| | < 6 months | 6-18 months | >18 months | Never |
|---|---|---|---|---|
| Spinal Examination | □ | □ | □ | □ |
| Physical Examination | □ | □ | □ | □ |
| Blood test | □ | □ | □ | □ |
| Chest x-ray | □ | □ | □ | □ |
| Spinal x-ray | □ | □ | □ | □ |
| Dental x-ray | □ | □ | □ | □ |
| Urine test | □ | □ | □ | □ |

Are you pregnant? □ Yes □ No
How many weeks? _____

Please check the type of care you desire so that we may be guided by your wishes when possible:

□ I prefer the doctor to select the type of care he feels is best for me □ Maximum improvement □ Temporary relief

Are you insured? □ Yes □ No Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office 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 the doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature _____ Date _____

Guardian's Signature _____ Date _____

# Notice of Privacy Practices

**Our Promise!**

Dear Patients: We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office. We have put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used i.e. internet, phone, faxes, copy machines, and charts.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

**How your HEALTH INFORMATION may be used to provide treatment**

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between chiropractic assistant, chiropractor, office manager, and the billing staff. In addition we may share your health information with referring physicians, clinical laboratories or other health care personnel providing you treatment.

**To Obtain Payment**

We may include your health information with an invoice used to collect payment for future treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information. We have updated our electronic billing software to be HIPAA compliant.

**To Conduct Health Care Operations**

Health information may be included in training programs for interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

**In Patient Reminders**

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as e-mail (unless you tell us that you do not want to receive these reminders).

**Abuse or Neglect**

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

**Public Health and National Security**

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic.

**For Law Enforcement**

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purpose, including under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

**Family, Friends, and Caregivers**
We may share your health information with family; however we will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

**Authorization to Use of Disclose Health Information**
Other than what is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

**Patient Rights:**

- *You have the right* to request restriction on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.
- *You have the right* to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.
- *You have the right* to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.
- *You have the right* to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.
- *You have the right* to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentations procedures will enable us to provide information on health information usage form April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may charge you a reasonable fee for your request.
- *You have the right* to obtain a copy of this Notice of Privacy Practices directly from our office at any time.
- *You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

We are required by law to maintain the privacy or your health information and to provide to you and your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our Privacy Practices we will be sure all of our patients receive a copy of the revised Notice.

**Patient Acknowledgment**
Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much you acknowledging your receipt of our policy by signing, dating, and returning this Notice.

_____ _____

**Patient Signature** **Date**

# Automobile Accident Questionnaire

Patient's Name _____ Today's Date _____
Date of Accident _____ Hour _____ □ AM □ PM
Location of accident: _____
Describe how accident happened in detail: _____
_____
_____
_____

In the Accident:

Were you the □ Driver □ Passenger □ Pedestrian Where were you seated in the vehicle? _____
Did you strike the other vehicle? □ Yes □ No Did the other vehicle strike you? □ Yes □ No
Were you struck from: □ Behind □ Front □ Left side □ Right side
Were traffic citations issued to: □ You □ Driver of your car □ Driver of other car □ None
Was your car heading: □ North □ South □ East □ West on _____ (street or highway)
Was the other car heading: □ North □ South □ East □ West on _____ (street or highway)

Were you aware of the impending impact/accident? □ Yes □ No
Were you wearing your seat belt? □ Yes □ No
Which way was you head facing upon impact: □ Straight ahead □ Turned around □ Up at mirror

Describe in detail your symptoms immediately following the accident: _____
_____
_____

Check symptoms you have had since the accident:

| | | | |
|---|---|---|---|
| □ Headache | □ Irritability | □ Short breath | □ Loss of smell |
| □ Neck Pain | □ Lower back pain | □ Fatigue | □ Loss of taste |
| □ Neck stiffness | □ Chest pain | □ Depression | □ Diarrhea |
| □ Sleeping problems | □ Pins/needles in arms | □ Loss of memory | □ Constipation |
| □ Upper back pain | □ Pins/needles in legs | □ Ears ringing | □ Cold feet/hands |
| □ Shoulder pain | □ Numbness in fingers | □ Loss of balance | □ Upset stomach |
| □ Tension | □ Numbness in toes | □ Fainting | □ Sweats/fever |

Symptoms Other than above: _____

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Have you lost time from work? □ Yes □ No Dates from _____ to _____
Did you require hospitalization? □ Yes □ No □ Emergency Room Only
If hospitalized, date admitted _____ date discharged _____
Name of Hospital _____
Address: _____
Attending Physician: _____

# Huntsville Chiropractic Clinic
Dr. David Land

## Insurance Information

**Your automobile insurance:**
Name: _____
Address: _____
City: _____
State/Zip: _____
Adjustor: _____
Phone Number: _____
Claim Number: _____
Policy Number: _____
Have you contacted your insurance company?
□ Yes □ No Date _____

**Your group health insurance company:**
Name: _____
Address: _____
City: _____
State/Zip: _____
Insured: _____
Adjustor: _____
Phone Number: _____
Claim Number: _____
Policy Number: _____
Have you contacted your insurance company?
□ Yes □ No Date _____
Are you covered under more than one group health policy? □ Yes □ No
If yes please supply the appropriate information.

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**Information Regarding:**

Other Vehicle Involved:
Drivers Name: _____
Insured Name: _____
Address: _____
City: _____
State/Zip: _____
Phone Number: _____
Insurance Company: _____
Address: _____
City: _____
State/Zip: _____
Adjustor: _____
Phone Number: _____
Policy Number: _____

Vehicle in which you were a passenger:
Drivers Name: _____
Insured Name: _____
Address: _____
City: _____
State/Zip: _____
Phone Number: _____
Insurance Company: _____
Address: _____
City: _____
State/Zip: _____
Adjustor: _____
Phone Number: _____
Policy Number: _____

Have you been contacted by a representative of the Insurance Company? □ Yes □ No
Date Contacted_____ By:_____ Insurance Company:_____

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**Have you retained an attorney? □ Yes □ No Date attorney retained:**_____
Name: _____
Address: _____
City: _____
State/Zip: _____
Phone: _____