



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:

- | | | | | |
|---|-------------------------------------|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chorea | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet Fever | |

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

- | | | | | |
|---|--|--|--|---|
| <p><u>General</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergy <input type="checkbox"/> Chills <input type="checkbox"/> Convulsions <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Depression <input type="checkbox"/> Neuralgia <input type="checkbox"/> Sweats <input type="checkbox"/> Tremors | <p><u>Muscle & Joint</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Bursitis <input type="checkbox"/> Foot trouble <input type="checkbox"/> Hernia <input type="checkbox"/> Low back pain <input type="checkbox"/> Lumbago <input type="checkbox"/> Neck Pain <input type="checkbox"/> Shoulder Pain <p>Pain or numbness in:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shoulders <input type="checkbox"/> Arms <input type="checkbox"/> Elbows <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Knees <input type="checkbox"/> Feet <input type="checkbox"/> Tailbone <input type="checkbox"/> Poor Posture <input type="checkbox"/> Sciatica <input type="checkbox"/> Spinal Curvature <input type="checkbox"/> Swollen joints | <p><u>Eyes, Ears, & Nose</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Colds <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Deafness <input type="checkbox"/> Dental Decay <input type="checkbox"/> Ear Ache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Ear Noises <input type="checkbox"/> Enlarged glands <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Eye pain <input type="checkbox"/> Failing vision <input type="checkbox"/> Far sightedness <input type="checkbox"/> Gum trouble <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Near sightedness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Sore throat <input type="checkbox"/> Tonsillitis | <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Chronic cough <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Spitting up blood <input type="checkbox"/> Spitting up phlegm <input type="checkbox"/> Wheezing <p><u>Gastro-intestinal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Belching or gas <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Colon trouble <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficult Digestion <input type="checkbox"/> Gall Bladder trouble <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Jaundice <input type="checkbox"/> Liver trouble <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pain <input type="checkbox"/> Poor appetite <input type="checkbox"/> Vomiting <input type="checkbox"/> Rectal pain | <p><u>Skin</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Dryness <input type="checkbox"/> Hives or allergy <input type="checkbox"/> Itching <input type="checkbox"/> Rashes <input type="checkbox"/> Varicose Veins <p><u>Genito-urinary</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bed wetting <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Bladder control <input type="checkbox"/> Kidney infection <input type="checkbox"/> Painful urination <input type="checkbox"/> Prostate trouble <p><u>Women Only</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Cramps <input type="checkbox"/> Excessive flow <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Irregular cycles <input type="checkbox"/> Menopause <input type="checkbox"/> Painful Flow <input type="checkbox"/> Vaginal Discharge |
|---|--|--|--|---|

	Yes	No
Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane or other support?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been hospitalized for anything other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>

Habits:

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of Last:

	< 6 months	6-18 months	>18 months	Never
Spinal Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 or 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 documentation procedures will enable us to provide information on health information usage from 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 of 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