



2055 N 156TH ST., OMAHA NE 68116

CONFIDENTIAL PATIENT INFORMATION

DATE _____

NAME _____

ADDRESS _____ **CITY** _____

STATE _____ **ZIP** _____

HOME # _____ **CELL PHONE#** _____ **EMAIL** _____

DOB _____ **SEX: M F** **MARITAL STATUS: M S W D** **#OF CHILDREN:** _____

OCCUPATION _____ **EMPLOYER** _____

EMPLOYER ADDRESS _____ **OFFICE PHONE** _____

STUDENT AT _____ **FULL TIME** _____ **PART TIME** _____

NAME OF SPOUSE _____ **OCCUPATION** _____

EMPLOYER _____ **PHONE** _____

NEAREST RELATIVE _____ **PHONE** _____

REFERRED BY _____

IS THE CONDITION DUE TO INJURY OR SICKNESS FROM EMPLOYMENT? _____

IS THE CONDITION DUE TO INJURY OR SICKNESS FROM AUTO ACCIDENT? _____

NUMBER OF DAYS LOST FROM WORK _____ **DATE SYMPTOMS APPEARED** _____

DATE ACCIDENT HAPPENED _____ **HAVE YOU HAD THE SAME OR SIMILAR
CONDITION? Y N IF YES, WHEN AND PLEASE DESCRIBE** _____

DATE OF LAST PHYSICAL _____

WHAT OPERATIONS HAVE YOU HAD? _____ **WHEN?** _____

SERIOUS ILLNESS? _____ **WHEN?** _____

HAVE YOU EVER SUFFERED FROM:

1. DIZZINESS _____ 6. ARTHRITIS _____ 11. DIGESTIVE DISORDERS _____

2. BACKACHES _____ 7. HEADACHES _____ 12. NERVOUSNESS _____

3. HEART TROUBLE _____ 8. NUMBNESS _____ 13. SINUS TROUBLE _____

4. DIABETES _____ 9. ASTHMA _____ 14. ANEMIA _____

5. HERNIA _____ 10. NEURITIS _____ 15. RHEUMATIC FEVER _____

16. CANCER _____

PURPOSE OF THIS APPOINTMENT _____

OTHER PHYSICIANS SEEN FOR THIS CONDITION _____

HAS A PHYSICIAN TREATED YOU FOR ANY OTHER CONDITIONS IN THE LAST YEAR ?

(IF YES PLEASE DESCRIBE) _____

WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? _____

FAMILY MEDICAL PHYSICIAN _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself- not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. I the patient am responsible to pay all sums for services rendered and products delivered, and those sums become due immediately upon billing. I further agree that interest will accrue and I will pay all principal and interest on all sums which remain unpaid after thirty(30) days at the rate of twelve percent(12%) per annum on all open balances. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

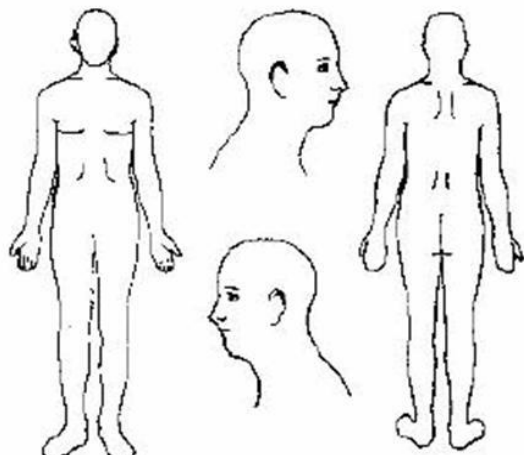
HEALTH INSURANCE Y N INSURANCE COMPANY _____

PATIENT SIGNATURE _____ **DATE** _____

GUARDIANS SIGNATURE AUTHORIZING CARE _____ **DATE** _____



WHAT IS YOUR MAJOR SYMPTOM? _____

<p>Place an "X" on the drawing below on areas causing you pain and a letter describing it</p> <p>A = ACHE B = BURNING S = STABBING N = NUMBNESS P = PINS & NEEDLES</p> 	<p style="text-align: center;">PAIN SCALE</p> <p style="text-align: center;">Please circle the number that best describes your pain</p> <p style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</p> <p>AGGRAVATING FACTORS</p> <p><input type="checkbox"/>Sitting <input type="checkbox"/>Standing <input type="checkbox"/>Walking <input type="checkbox"/>Bending <input type="checkbox"/>Stooping <input type="checkbox"/>Reaching <input type="checkbox"/>Twisting Looking Up <input type="checkbox"/>Looking Down <input type="checkbox"/>Sleeping <input type="checkbox"/>Sneezing <input type="checkbox"/>Lifting <input type="checkbox"/>Coughing Straining <input type="checkbox"/>Rest <input type="checkbox"/>Laying On Back <input type="checkbox"/>Driving <input type="checkbox"/>Typing <input type="checkbox"/>Scooping <input type="checkbox"/>Household Chores <input type="checkbox"/>Exercise <input type="checkbox"/>Stair Stepping <input type="checkbox"/>Other _____</p> <p>RELIEVING FACTORS</p> <p><input type="checkbox"/>Sitting <input type="checkbox"/>Standing <input type="checkbox"/>Laying <input type="checkbox"/>Knees Bent Up <input type="checkbox"/>Support <input type="checkbox"/>No Movement <input type="checkbox"/>Movement <input type="checkbox"/>Heat <input type="checkbox"/>Ice <input type="checkbox"/>Ibuprofen <input type="checkbox"/>Medicine <input type="checkbox"/>Rest <input type="checkbox"/>Stretching/Exercise <input type="checkbox"/>Adjustments <input type="checkbox"/>Other _____</p>
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WHEN WAS THE FIRST TIME YOU NOTICED THIS PROBLEM: _____

HOW DID IT ORIGINALLY OCCUR? _____

HAS IT BECOME WORSE RECENTLY? YES NO SAME BETTER GRADUALLY WORSE
IF YES, WHEN AND HOW? _____

HOW FREQUENT IS THE CONDITION? CONSTANT DAILY INTERMITTENT NIGHTS ONLY
WHAT PERCENT OF THE DAY DO YOU NOTICE YOUR SYMPTOMS? _____

ARE THERE ANY OTHER SYMPTOMS OR CONDITIONS THAT MAY BE RELATED TO YOUR MAJOR SYMPTOM? (IF YES PLEASE DESCRIBE) _____

ARE THER OTHER UN-RELATED HEALTH PROBLEMS? Y N IF YES, PLEASE DESCRIBE: _____

HAVE YOU EVER BROKEN ANY BONES? Y N IF YES, PLEASE EXPLAIN _____

LIST ANY MAJOR ACCIDENTS YOU HAVE HAD OTHER THAN THOSE THAT MIGHT HAVE BEEN MENTIONED ABOVE _____

TO YOUR KNOWLEDGE, HAVE YOU HAD ANY DISEASES, MAJOR ILLNESSES OR INJURIES NOT INDICATED ON THIS FORM FOR EITHER IN THE PAST OR PRESENT? Y N IF YES, PLEASE EXPLAIN: _____

HAVE YOU SEEN A CHIROPRACTOR BEFORE? _____

WOMEN ONLY: ARE YOU PREGNANT OR IS THERE ANY POSSIBILITY THAT YOU MAY BE PREGNANT? YES NO UNCERTAIN

DOCTOR'S SIGNATURE _____ DATE: _____



PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent from uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical record and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name _____ **Signature:** _____ **Date** _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients,

The misuse of Personal Health information, (PHI) has been identified as a national problem causing inconvenience, aggravation and money. We want you to know that all of our employees, managers, and physicians continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the Privacy Rule. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Eric M. Clements, D.C.