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?):_____

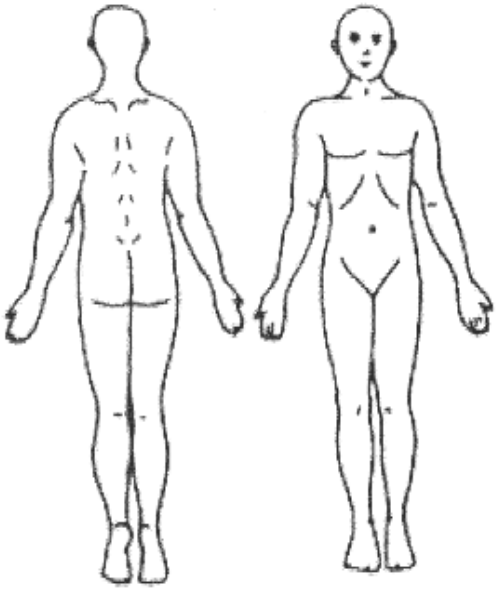
_____

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
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. heck what may apply to you; if non apply, check the "I DENY" box.

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**

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **dizziness** ☐ **limb weakness** ☐ **numbness** ☐ **slurred speech** ☐ **tremor**
☐ **facial weakness** ☐ **loss of consciousness** ☐ **seizures** ☐ **stress** ☐ **loss of balance**
☐ **headache** ☐ **loss of memory** ☐ **sleep disturbance** ☐ **strokes**

Psychologic: **☐ I DENY having any of the symptoms or problems listed below.**

☐ anhedonia ☐ loss or change in appetite ☐ behavioral change ☐ convulsions ☐ memory loss
☐ anxiety ☐ confusion ☐ insomnia ☐ bi-polar disorder ☐ depression ☐ mood change

Allergy: **☐ I DENY having any of the symptoms or problems listed below.**

☐ anaphalaxis ☐ food intolerance ☐ acute nasal congestion ☐ chronic nasal congestion ☐ sneezing

Hematological: **☐ I DENY having any of the symptoms or problems listed below.**

☐ anemia ☐ bleeding ☐ fatigue ☐ blood clotting ☐ bruising easily ☐ lymph node swelling

Male: **☐ I DENY having any of the symptoms or problems listed below.**

☐ burning urination ☐ frequent urination ☐ prostate problems ☐ urine retention
☐ erectile dysfunction ☐ hesitancy/dribbling

Female: **☐ I DENY having any of the symptoms/problems and/or using any of the items listed below.**

☐ birth control ☐ cramps ☐ hormone therapy ☐ irregular menstruation ☐ vaginal bleeding
☐ breast lumps/pain ☐ frequent urination ☐ pregnancy ☐ urine retention ☐ vaginal discharge

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

father ☐ alive ☐ deceased ☐ normally developed ☐ no significant disease ☐ has/had:_____
mother ☐ alive ☐ deceased ☐ normally developed ☐ no significant disease ☐ has/had:_____

Social History: **Mark all that apply below.**

Alcohol: **☐ do not drink alcohol ☐ social consumption only ☐ drink the following regularly (mark below)**
quantity of _____ oz./glasses per ☐ day ☐ week ☐ month

Substance: **☐ never used illegal drugs ☐ has not used illegal drugs since _____ .**
☐ never used IV drugs ☐ used illegal drugs for _____ (how long?)

Tobacco: **☐ Do not use ☐ Type_____ Amount_____**

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) ☐ Myself ONLY

☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Other (be specific):_____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: _____/_____/ _____ Primary Care Physician: _____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Living Tree Center for Healing 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 Living Tree Center for Healing will be credited to my account upon receipt. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctors of Living Tree Center for Healing to treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. As the patient I also agree that I am fully responsible for all bills incurred at this office. We are not a Medicaid Provider and do not accept Medicaid, any services incurred will be patient responsibility.

Patient Print Name: _____ Patient's Signature: _____Date: _____

Consent to treat a Minor: _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

Rev 09/1/15

Privacy Practice Information (HIPPA)

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: Nigel Brayer
ADDRESS: 11443 State Road
North Royalton, Ohio 44133
PHONE: (440)877-9440

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 $15 fee for a missed or forgotten chiropractic 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. Any massage, acupuncture or nutritional appointment that is not rescheduled or canceled with less than 24 hours notice, the total cost of appointment will still be owed.

- **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.