New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date of Injury | Date symptoms appeared

Have you ever had same condition? ○ No ○ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ○ No ○ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ○ No ○ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

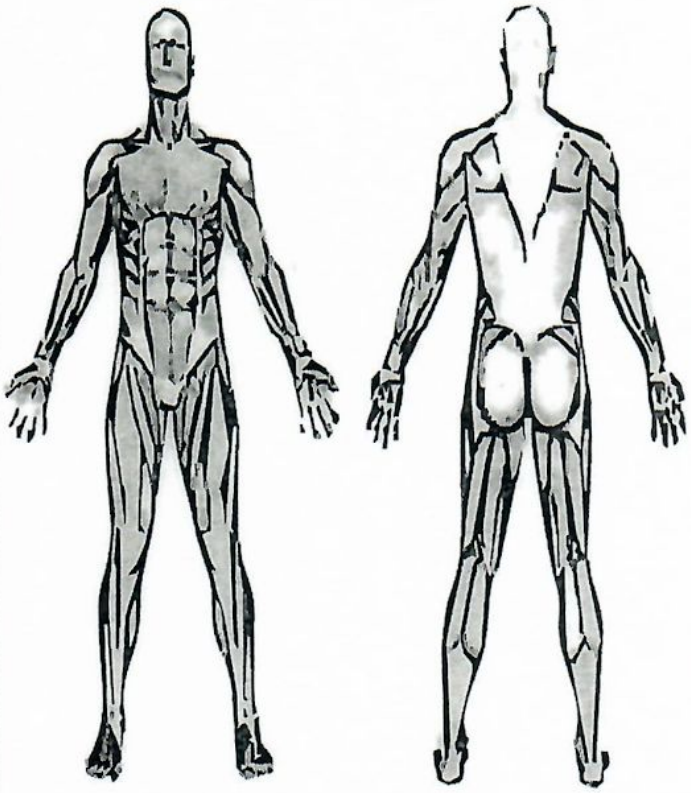
Spouse's or guardian's signature _____ Date _____

Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing



Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam | Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	○ No ○ Yes
Do your symptoms interfere with daily life?	○ No ○ Yes
Does pain wake you up at night?	○ No ○ Yes
Are your symptoms worse during certain times of the day?	○ No ○ Yes
Do changes in weather affect your symptoms?	○ No ○ Yes
Do you wear orthotics?	○ No ○ Yes
Do you take vitamin supplements?	○ No ○ Yes

What activities aggravate your symptoms?

Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

Seminole Chiropractic Wellness Center
Dr. Randal L. Butch

This office is committed to providing patients with quality health care services delivered with dignity, respect and concern. Fulfilling this commitment requires the efforts of the doctors, therapist, staff and patient working together as a team to obtain maximum results. Patient satisfaction is a vital interest to our staff. This facility is required by law to abide by the terms of the Health Care Privacy Notice, Patient Bill of Rights and Informed Consent as well as other applicable federal and state laws governing privacy practices in health care. Below is our Informed Consent, please sign and date the bottom of the page.

Informed Consent

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of procedure(s) which the doctor/provider feels at the time is in my best interest. I understand and informed that, as in the practice of medicine, as in the practice of chiropractic there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations and sprains. Treatment may include but not limited to chiropractic adjustments, chiropractic procedures, physical therapy, and diagnostic x-ray.

As our patient you can voluntarily stop care or ask questions about reasonable alternatives to the procedure(s) we recommend including but not limited to rest, exercises, home applications of therapy, and/or referral to a medical/surgical specialist.

Patients have the right to refuse treatment, but must be aware of the probable consequence of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Any supplemental recommendations that are mentioned are simply nutritional and herbal support for someone with said noted condition and someone without said noted condition. Please be advised that any suggested nutritional, herbal and dietary advice is not intended as a primary treatment or therapy for any disease or particular bodily symptom. The nutrition and herbs recommended are provided solely to support the normal physiological processes of the human body.

I hereby give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider at this facility.

_____
Print Name of Patient

_____ _____
Signature of Patient (if minor, parent or legal guardian must sign Date

Seminole Chiropractic Wellness Center
Dr. Randal L. Butch

Consent for Open Treatment Area and Permission to Share Patient Information

I understand that Seminole Chiropractic Wellness Center may leave a phone message in the effort and if necessary to obtain or provide information regarding appointments, and account occurrences. In addition, I also understand that Seminole Chiropractic Wellness Center may send postcards and billing statements to the address listed on file.

Further more, I understand that Seminole Chiropractic Wellness Center uses an open treatment area where conversations between the patient and the doctor and/or staff may be overheard by other patients and facility members. If at any time the patient does not feel comfortable, he or she may ask the doctor and/or staff to be put in a closed treatment area.

By signing the line below, I give full consent to Seminole Chiropractic Wellness Center to mail post cards and billing statements to the address listed on file.

Check all that apply:
Voicemail messages may be left on ____Home Phone ____Cell Phone ___Work Phone
_____Phone messages may be left with Persons living in my home
_____Phone messages regarding appointments may be left with coworkers

Information regarding my treatment may be discussed with the following individuals:

1._____ _____ _____
Name Relationship Phone Number

2._____ _____ _____
Name Relationship Phone Number

Information regarding my treatment may **NOT** be discussed with the following individual:

1._____ _____ _____
Name Relationship Phone Number

2._____ _____ _____
Name Relationship Phone Number

I may revoke this Consent/Authorization at any time. A written revocation which will not be effective until received and approved by the Privacy Officer.

_____ _____
(Patient Signature/Guardian/Authorized Representative) Date

5/4/2013

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

PATIENT/CLIENT RIGHTS

1. The right to obtain information, about his/her condition, in terms he/she can understand.
2. To make informed decisions regarding your care planning, and offer suggestions on how we may improve our service/care.
3. To have your pain assessed as it relates to the service provided.
4. The right to considerate and respectful care.
5. To agree to or refuse any part of the plan of service or plan of care.
6. The right to continuity of care.
7. The right to privacy and confidentiality of medical condition and medical records.
8. The right to examine and receive an explanation of his/her bill.
9. The right to file a grievance.
10. The right to know the rules and regulations, of the company, that apply to his/her responsibility as a patient/client.
11. To obtain service without regard to race, creed, national origin, sex, age, disability or illness, or religious affiliation.
12. To have your communication needs met.

PATIENT/CLIENT RESPONSIBILITIES

1. To supply us with needed insurance information necessary to obtain payment for services and assume responsibility for charges not covered.
2. The responsibility to provide correct and complete information.
3. To ask questions regarding, your individualized, Plan of Treatment which you do not understand.
4. To arrive, in a timely manner, for scheduled appointments or notify us in advance to make other arrangements.
5. The responsibility to comply with instructions.
6. To take responsibility for the outcome when refusing treatment.
7. The responsibility to fulfill financial obligations.
8. The responsibility to be respectful and considerate to those providing them with care.

Complaints and Concerns

If you are concerned that Seminole Chiropractic Wellness Center may have violated your privacy rights or if you disagree with any decisions we made regarding access or disclosure of your personal health information, please contact our Privacy/ Security officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. Seminole Chiropractic Wellness Center will not tolerate any retaliatory acts against anyone who files a complaint. For further information of Seminole Chiropractic Wellness Center health information practices, or if you have a complaint, please contact the following:

Randal Butch
Privacy/Security Officer
Seminole Chiropractic Wellness Center
8229 113th St. North
Seminole F.L. 33772
Phone: 727.398.3999
Fax: 727.397.3777

Signature: _____ Date: _____