PERSONAL INFORMATION

Date: ___/___/___ Social Security #:_____/____/_____

First Name: _____

Middle: _____

Last Name: _____

Nickname: _____

Birthday: ____/_____/_____ Age:_____

Address: _____

City: _____ State: _____ Zip:_____

Best Contact Number: Cell / Home / Work

Phone #: _____

E-mail: _____

Occupation:_____

Employer:_____

Address:_____

City: _____ State: _____ Zip: _____

Status (Please Circle): Single / Married / Divorced Separated / Widowed

Do you have any children? YES / NO # _____

OB/GYN Practice: _____

Dr /Midwife Name: _____

Due Date: _____

Baby's Gender: M F Waiting Too Soon

Referred by: _____

Hunt For Wellness
CHIROPRACTIC
Family & Injury Care

Get Well and Stay Well

The best way to stay up to date with our office and the latest health information is to be a member of our website.
Please provide the following details so we can establish you as a member of our website:

Preferred email: _____

Please check the health subjects that most interest you:

- ☐ Headaches and Neck Pain
- ☐ Backaches and Sciatica
- ☐ Children's Health Issues
- ☐ Exercise and Fitness
- ☐ Diet and Nutrition
- ☐ Stress management
- ☐ Wellness Topics
- ☐ Women's Health

IN CASE OF EMERGENCY

Whom should we contact:_____

Relation:_____

Phone: _____C / H / W

Other Phone:_____

Medical Doctor:_____

Doctor Phone Number: _____

Pregnancy Health History Form

This form is important as it will help us focus on assisting our patients to the best of our ability. With complete information we can serve our patients in their goal for optimal function and allow each patient to achieve better self-awareness, become stronger, healthier, and improve adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time and contribute to health problems.

Please explain in detail the reason for your visit:

Current Health Concerns: Is your visit today to ensure optimum health, function and wellness and to provide a better pregnancy experience? **YES / NO**

IF YOU ARE IN PAIN OR ACQUIRED AN INJURY:

What happened or what were you doing?

_____

_____

_____

_____

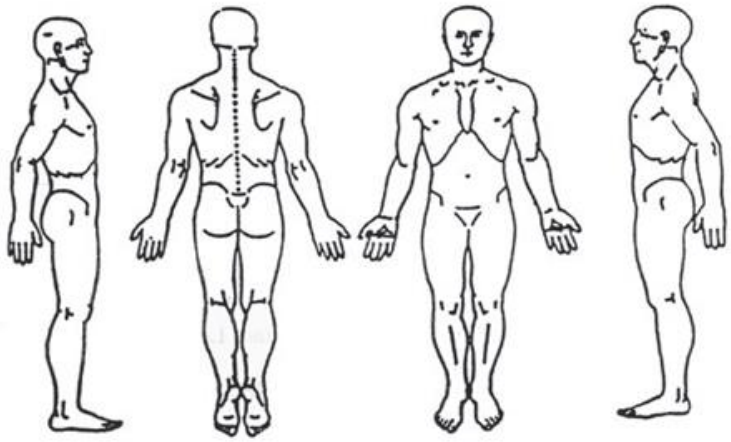
_____

CIRCLE YOUR PAIN LEVEL

1=Least, 10=Most

Discomfort-1–2--3--4--5--6--7--8--9--10--Intense

MARK THE LOCATION OF PAIN/DISCOMFORT ON THE DIAGRAM BELOW:



IS YOUR CONDITION INTERFERING WITH

[ ] Work [ ] Sleep [ ] Daily Routine

CIRCLE WHAT BEST DESCRIBES YOUR PAIN:

Occasional (on & off) / Constant
Worse: Activity / Rest
Worse: Morning / Mid-day / Night
Worse: Sleep / Sitting / Standing

CIRCLE WHAT BEST DESCRIBES YOUR PAIN:

DULL / ACHE / SHARP / STABBING / THROBBING

BURNING / ELECTRICAL / RADIATING / CRAMPING

HAVE YOU NOTICED:

Swelling in your arms or legs? **YES / NO**

Low back pain? **YES / NO**

Upper back pain? **YES / NO**

Neck pain? **YES / NO**

Rib or chest pain? **YES / NO**

Foot/Ankle pain? **YES / NO**

Arm/Hand numbness/tingling? **YES / NO**

Digestive complaints? **YES / NO**

Heartburn, Constipation, Re-flux, OTHER*

Nausea or vomiting? **YES / NO**

Dizziness or lightheaded? **YES / NO**

Headaches? **YES / NO**

Heart palpitations? **YES / NO**

Do you have or have you had any of the following diseases, medical conditions, or procedures?

Y / N Heart Attack/Stroke	Y / N Heart Surgery/Pacemaker	Y / N Heart Murmur
Y / N Artificial Valves	Y / N Alcohol/Drug abuse	Y / N Venereal Disease
Y / N Shingles	Y / N Psychiatric Problems	Y / N Frequent Neck Pain
Y / N High/Low Blood Pressure	Y / N Fainting/Seizures/Epilepsy	Y / N Rheumatic Fever
Y / N Ulcers/Colitis	Y / N Cancer	Y / N Sinus Problems
Y / N Difficulty Breathing	Y / N Chemotherapy	Y / N Low Back Problems
Y / N Congenital Heart Defect	Y / N Hepatitis	Y / N Glaucoma
Y / N Severe/Frequent Headaches	Y / N Emphysema/Asthma	Y / N Mitral Valve Prolapse
Y / N Artificial Bones/Joints/Implants	Y / N HIV+/AIDS/ARC	Y / N Anemia/Diabetes
Y / N Kidney Problems	Y / N Tuberculosis	Y / N Arthritis
Y / N Food Sensitivities	Y / N Brain Fog	Y / N Allergies

About Your Pregnancy:

Is this your first pregnancy? **YES / NO**

If this is not your first, how many times have you been pregnant? _____

Have you had any complications with previous pregnancies? **YES / NO**

If YES; Please explain _____

If you have had miscarriage(s), how far along in your pregnancy did it occur?

_____

Was this pregnancy planned? **YES / NO**

What is the estimated date of delivery? _____

Do you have a birth plan? **YES / NO** Any questions about your birth plan? **YES / NO**

Any special arrangements for the birth? (**Planned cesarean, water delivery, home birth, OTHER)**

_____

Are you planning on breast feeding post-delivery? **YES / NO**

Blood Pressure prior to pregnancy? **Within Normal Range, Low, High?**

What is your current blood pressure range? **Within Normal Range, Low, High?**

Have you changed your diet since learning of your pregnancy? **YES /NO**

Have you smoked prior to/or during this pregnancy? **YES / NO / QUIT**

Have you had any alcohol during this pregnancy? **YES / NO**

Are you currently taking any medication? **YES / NO** _____

Are you taking prenatal vitamins? **YES / NO** _____

Are you taking any health supplements? **YES / NO** _____

How much water do you drink daily? _____

Do you exercise? **YES / NO** Hours per week? _____

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

_____

List any past serious accidents with dates: _____

_____

Please list anything that you may be allergic to: _____

_____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

YOUR RIGHTS

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. *For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html*

Patient Signature: _____ *Date:* _____

Consent for examination and treatment:

I do herby consent to the evaluation and treatment of care by the doctors and staff at Hunt for Wellness. I understand that there may be remotely associated risks with examinations and treatment, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not, is determined by looking at the level of risk and comparing it to the expected benefit. I understand that I may ask the doctor to stop the examination or treatment at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests. I understand my right to Informed Consent and to may an Informed Decision.

Patient Signature: _____ *Date:* _____