Hunt For Wellness CHIROPRACTIC
Family & Injury Care

PERSONAL INFORMATION

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

First Name / Nombre:______________________________

Middle / Segundo:________________________________

Last Name:_______________________________________

Nickname / Apodo:_______________________________

Address / Direccion:_____________________________

City / Ciudad:_________ State/Estado:_____ Zip:______

Birthday / Cumpleanos:___/___/____ Age / Edad:______

Cell Phone # / Telefono de casa:__________________

Work/Home Phone # / Telefono de trabajo:_________________

Cell Carrier for Text Reminders:_______________________

E-mail:____

Referred by / Referido por:________________________

Employer / Empleador:____________________________

Address / Direccion:_____________________________

City / Ciudad:_________ State/Estado:_____ Zip:______

Occupation / Occupacion:__________________________

Status / Estatus:

[ ] Single / Soltero [ ] Married / Casado

[ ] Divorced / Divorciado [ ] Separated / Separado

[ ] Widowed / Viudo

Do you have any children? / Tiene hijos? [ ] Yes/Si [ ] No

How many? / Cuantos?:______________

IN CASE OF EMERGENCY / EMERGENCIA

Whom should we contact / Persona de contacto:_______________________________________

Home Phone # / Telefono de casa:__________________

Work Phone # / Telefono de trabajo:________________

Other Phone # / Otro Numero:______________________

Relation / Relacion:______________________________

Medical Doctor / Doctor Medico:____________________

Doctor's # / # de doctor medico:____________________

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 address: ________________________________

Please check the health subjects that most interest you:

☐ Headaches and Neck Pain ☐ Diet and Nutrition

☐Backaches and Sciatica ☐ Stress management

☐Children's Health Issues ☐ Wellness Topics

☐Exercise and Fitness ☐ Women's Health Issues

REASON FOR VISIT

Reason for today's visit: **[ ]** Emergency **[ ]** New Injury **[ ]** Old Injury **[ ]** Chronic Pain **[ ]** Wellness

Are you in pain: **[ ]** Yes **[ ]** No **Rate your pain** with the following pain scale: **discomfort**--**1**--**2**--**3**-**4**--**5**--**6**--**7**--**8**--**9**--**10**--**intense**

When did your condition / accident occur? ____/_____/_____ Where did your injury occur? ___________________________________

Please explain what happened: ____

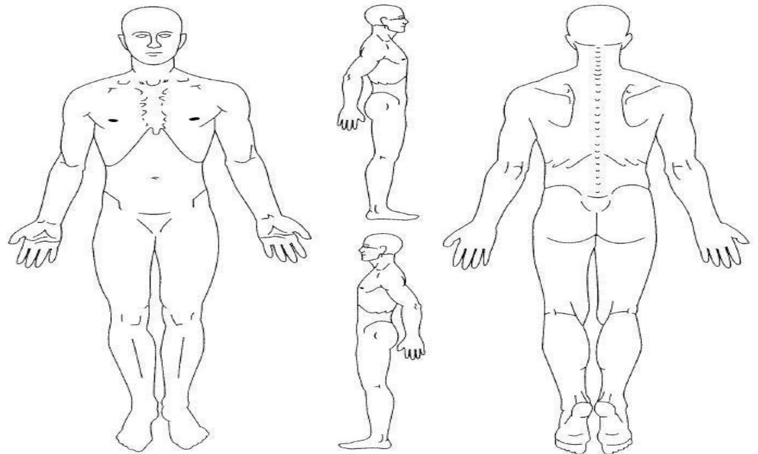
Is your condition getting worse? **[ ]** Yes **[ ]** No **[ ]** Constant **[ ]** Comes and Goes

Is your condition interfering with your: **[ ]** Work **[ ]** Sleep or **[ ]** Daily Routine? If so, how? ____

Has this or something similar happened in the past?

[ ] Yes **[ ]** No Please Explain:____________________________

Using the adjacent body charts, please circle ALL affected areas.



Have you been treated by a Medical Physician for this condition? **[ ]** Yes **[ ]** No If so, Where?

____

Have you ever been treated by a Chiropractor?

[ ] Yes **[ ]** No If Yes, how long ago? _______________

Clinic / Dr's name: ____________________________

Clinic Phone #: _______________________________

Are you taking any of the following medications? **[ ]** Nerve Pills **[ ]** Pain Killers (including aspirin) **[ ]** Muscle Relaxers **[ ]** Blood Thinners **[ ]** Tranquilizers **[ ]** Steroids **[ ]** Diabetic **[ ]** Insulin **[ ]** Thyroid **[ ]** Cholesterol **[ ]** Digestion **[ ]** Other(s)_________________________________

Do you have or have you had any of the following diseases, medical conditions, or procedures? (please circle Y or N)

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

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: ____

Family Health History: ____

Do you take supplements or Vitamins? **[ ]** Yes **[ ]** No Do you exercise? **[ ]** Yes **[ ]** No Hours per week ______________

Do you use tobacco? **[ ]** Yes **[ ]** No How much? ________ How long? _________ Are you dieting: **[ ]** Yes **[ ]** No Since: __________

Do you drink alcohol? **[ ]** Yes **[ ]** No How much? __________ Are you wearing: **[ ]** Shoe Lifts **[ ]** Inner Soles **[ ]** Arch Supports

For Women: Are you taking Birth Control? **[ ]** Yes **[ ]** No Are you pregnant? **[ ]** Yes **[ ]** No If so, how many weeks? ______________

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 1-877-696-6775, 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.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you**
  We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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:* ______/_________/_________