Desert Springs Chiropractic Center

127 W. Juanita Ave, #110 Mesa, AZ 85210
(480) 668-1199/ Fax (480) 668-7300

Name ______________________________ Address ______________________________
City ____________________ State ________ Zip __________ Home ph# ______________
Cell# (For confirming apt.): __________________ E-mail Address : ______________________
SSN _____/_____/_____ Date of birth ____/____/____ Age _____ Height ________ Weight ________
Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ # of children _____ Spouse's name ______________________
Employer ______________________________ Address ______________________________
City __________________ State ____ Zip ________ Wk ph: ____________ Occupation ____________

What is the name of your family physician? ______________ What city are they located in ______________
Physician Phone #: ______________________
Have you ever had Chiropractic care before? yes ☐ no ☐ If yes, doctor name: __________ Date of last visit ________
If you are experiencing any pain (neck pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity
1. ______________________________________ For how long? ____________________
2. ______________________________________ For how long? ____________________

Has this problem been getting worse ☐ staying the same ☐ ?

Have you at any time in the past ever suffered a work injury? yes ☐ no ☐ If yes, what is the date of injury? ____/____/____
Do you have an attorney representing you for this work injury? yes ☐ no ☐ If yes, who is your attorney? ______________

Have you been involved in an auto accident in the last 12 months? yes ☐ no ☐ If yes, what is the date of injury? ____/____/____
Do you have an attorney representing you for this auto injury? yes ☐ no ☐ If yes, who is your attorney? ______________
How many other passengers were in the car with you? ______________________________

List other doctors consulted for these conditions? 1) __________________ 2) __________________
If due to an auto accident, what is the name of your auto insurance company? ______________________

Health Insurance Co. Name ______________________________ Policyholder ______________
Name of Spouse's health insurance (If applicable) ______________________ Policyholder ______________
Spouse's Health Insurance Claims address ______________________ Policy number ______________

The rating scale below is designed to measure the degree to which any aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your condition is preventing you from doing what you would normally do, or from doing it as well as you normally would. **Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.**

PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF PROBLEM FOR EACH ACTIVITY.
0 means no pain at all, and a score of 10 means the activity has been totally disrupted or prevented by your health condition (pain and/or symptoms).

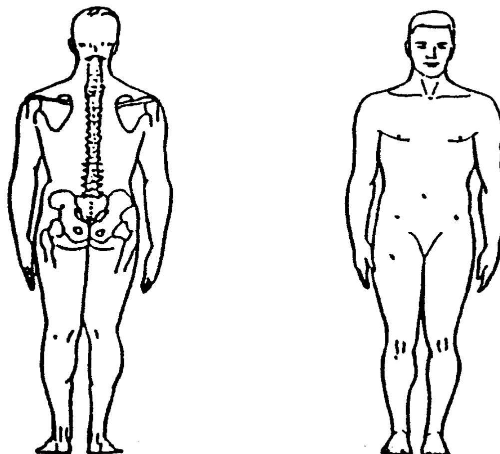
0	1	2	3	4	5	6	7	8	9	10
Completely able to function with NO pain or limitations					**Able to function but with discomfort or pain**					**Totally unable to function**

RATE:

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc) ________
2. RECREATION: hobbies, exercise, sports, and other similar leisure time activities. ________
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. ________
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs, such as that of a homemaker or volunteer worker. ________
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) ________
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. ________

Please **mark the exact location of your pain on the diagram below**. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

MARK THESE DIAGRAMS



Method of payment for today's charges: ☐CASH ☐ CHECK ☐ CREDIT CARD ☐ ______________________

Notice: All charges are due on the date of service.

Patient's Signature ____Date____________________

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Patient History Form

Name: ______________________________ Date: ____/____/____

Symptom 1: ______________________________

When did the symptom begin ______________________________
Did symptom begin **SUDDENLY** or **GRADUALLY** ? (Circle one)

How did the symptom begin? ______________________________

What makes the symptom worse (please describe) ______________________________

What Makes the symptom better (circle all that apply).
Rest **Ice** **Heat** **Massage** **Chiropractic** **Pain Meds** **Muscle relaxers** **Nothing**
Other (please describe) ______________________________

Describe the quality of the symptom: **Sharp** **Dull** **Achy** **Throbbing** **Numb** **Tingling** **Stabbing**
Other (please describe) ______________________________

Does the symptom radiate to other parts of your body? (i.e. down your leg, go to your arm) **YES** **NO**

(please describe) ______________________________

Is the symptom affected by time of day or night? (circle one) **Morning** **Afternoon** **Evening** **Night** **None**

Symptom 2: ______________________________

When did the symptom begin ______________________________
Did symptom begin **SUDDENLY** or **GRADUALLY** ? (Circle one)

How did the symptom begin? ______________________________

What makes the symptom worse (please describe) ______________________________

What Makes the symptom better (circle all that apply).
Rest **Ice** **Heat** **Massage** **Chiropractic** **Pain Meds** **Muscle relaxers** **Nothing**
Other (please describe) ______________________________

Describe the quality of the symptom: **Sharp** **Dull** **Achy** **Throbbing** **Numb** **Tingling** **Stabbing**
Other (please describe) ______________________________

Does the symptom radiate to other parts of your body? (i.e. down your leg, go to your arm) **YES** **NO**

(please describe) ______________________________

Is the symptom affected by time of day or night? (circle one) **Morning** **Afternoon** **Evening** **Night** **None**

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ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Prolonged Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Prolonged Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
______________________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
______________________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Patient signature: ____

Printed Name: ____

Today's Date: ______/______/______

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Patient Name:____ **Date**: ____/____/_____

Please mark **P (Past)**, **C (Currently)** or **LEAVE BLANK (Never)**

___ Headaches
___ Pregnant (current)
___ Dizziness
___ Prostate Problems
___ Neck pain
___ Upper Back Pain
___ Mid Back Pain
___ Low Back Pain
___ Shoulder Pain
___ Ulcers
___ Heartburn/Acid Reflux
___ Jaw Pain / TMJ
___ Digestive Problems
___ Heart Problem
___ High Blood Pressure
___ Low Blood Pressure
___ PMS
___ Menstrual Problems
___ Diarrhea/ Constipation
___ Trouble sleeping
___ Shoulder Pain
___ Scoliosis
___ Spinal Curvature
___ Concussion
___ Hip Pain
___ Asthma
___ Lung Problems
___ Depression
___ Anxiety
___ Mood Swings
___ ADD/ ADHD
___ Bed Wetting
___ Ringing in Ears
___ Sinus/Allergy Problems
___ Swollen/Painful Joints
___ Foot or Knee Problems
___ Frequent Colds/Flu
___ Erectile dysfunction
___ Sexual Dysfunction
___ Eating Disorders
___ Tingling/ Numb arms, hands, fingers
___ Tingling/ Numb legs,feet, toes

Previous Surgeries (date of procedure):____

____

Family History

☐ Cancer (type):____

☐ Self ☐ Sibling ☐ Mother ☐ Father ☐ Grandfather ☐ Grandmother

☐ Osteoporosis / Osteopenia / Decreased Bone Mass who:_______________________

☐ Diabetes ☐ Stroke ☐Genetic Disorders (explain)_______________________

Social History

☐ Tobacco / Smoking ☐ Alcohol Drinks/week ____ ☐ Recreational Drugs ☐ Medical Marijuana

Medications

☐ Birth Control ☐ Blood Thinners (Coumadin, etc.) ☐NSAID ☐ Narcotic Pain Meds
☐ Muscle Relaxers
☐ Fluoroquinolone Antibiotics in last 6 months (ex. Cipro, Factive, Levaquin, Avelox, floxin medications)
☐ Statin Drugs (ex. Lipotor, atorvastatin, Pravochol, Crestor, Zocor, Lescol, Vytorin, Simvastatin, etc.)

HIPAA Notice of Privacy Practices

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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.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and/or others outside our office that are involved in your care and/or treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician, imaging center, etc. to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff or medical students, licensing, and conducting or arranging for other business activities. This office utilizes and "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting and exercise area at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. There are various interpretations under federal law with respect to what is known as "incidental disclosure" of health information. It is our view that the kinds of matters related in an "open door" environment are incidental matters. In the event you need to discuss a private matter with our physician or staff you can request a private area for consultation.

We may publish patient testimonials, contest winners, office-related activities or photographs taken in the office in such things as newsletters, handouts, websites, advertising, social media or other marketing. If you choose not to authorize this information, your decision will have no adverse effect on your care at our facility or your relationship with our staff. If you choose not to provide us with authorization, please notify us in writing.

We may use or disclose your PHI in the following situations without your authorization. These situations include: Food and Drug Administration requirement, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donations, Research, Criminal Activity Investigation, Military Activity and National Security, Worker's Compensation, regarding Inmates, Required Use and Disclosure, Under the law, we must make a disclosure to you if and when required by the Secretary of the Dept. of Health and Human Services to investigate or determine our compliance with requirements of Section 164-500.

Other Permitted and Required Uses and Disclosures will be made with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure in the authorization.

YOUR RIGHTS
The following is a statement to your rights with respect to your protected health information (PHI).

You have the right to inspect and copy your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be specific restriction requested and to whom you want the restriction to apply in writing.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use disclosure of your PHI, your PHI will not be restricted. You have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon, request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.

We have the right to change the terms of this notice, and the changes will be applied to all information we have about you. The new notice will be available upon request, in our office and on our website. You have the right to object or withdraw as provided in this notice.

Complaints
You can complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **November 25, 2019.**

Please list the names of anyone we would be allowed to discuss your protected medical information (PHI).

Name:______________________________ Ph#:________________ Relationship:______________

Name:______________________________ Ph#:________________ Relationship:______________

Name:______________________________ Ph#:________________ Relationship:______________

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by telephone at our main phone number (480) 668-1199.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices.

______________________________ ______________________________
Patient or Legally Authorized Individual Signature | Date

______________________________ ______________________________
Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, etc.)