

Artful Chiropractic

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Dr. Steve Baroody

Patient Information Sheet

Date: _____ Name: _____
 Address: _____
 City: _____ State/Zip: _____
 Home Phone: (____) _____ - _____ Social Security Number: _____
 In case of emergency, contact: _____ Phone: (____) _____ - _____
 Birthdate: ____/____/____ Male: _____ Female: _____
 mo dy yr
 Height: _____ Weight: _____ Shoe Size: _____
 Please list your hobbies, sports, and other interests:

Work Information

Position: _____
 Employer: _____ Supervisor: _____
 Employer Address: _____
 Phone at work: (____) _____ - _____ ext _____

Physician Information

Name of Primary Physician: _____
 Address: _____
 Phone: (____) _____ - _____ May we send a report? Yes No

Visit Information

How did you hear about us? _____
 What is the reason for your visit today? _____

Insurance Information

Name of Insurance Company: _____ Phone: _____
 Policy Number: _____ Group number: _____
 Name of Insured: _____ Relationship to Patient: _____

Is your condition due to an accident _____ or illness _____?
 If an accident, did it occur at work? _____ Date of accident: _____

Patient to complete the following sections:

Patient Last Name:	First Name:	MI:	Daytime Phone:
Date:	SS Number:		Evening Phone:

Please list the reasons/condition for your visit in order of importance, most important at the top:	Date you first noticed:	Pain &/or Symptoms Circle the number that best reflects your condition: (0= no effect 10= severe)	Pain &/or Symptoms Circle how much of the time your experience your condition:
A.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
B.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
C.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
D.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%

For each condition listed above, please indicate how it happened:

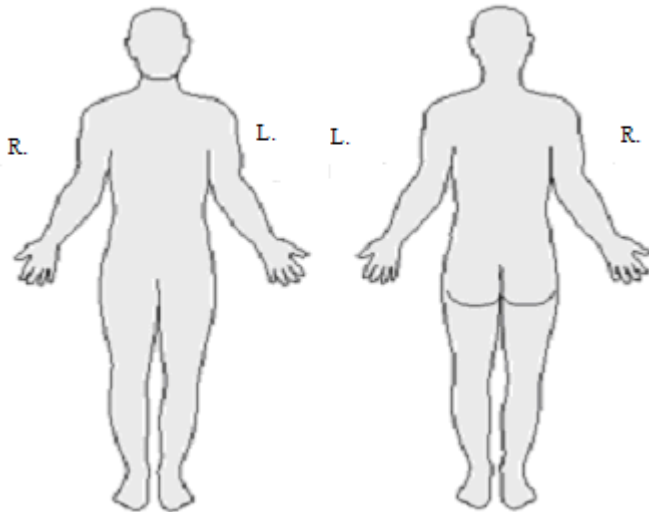
- A. Developed over time Illness Injury Auto accident Other _____ I don't know
- B. Developed over time Illness Injury Auto accident Other _____ I don't know
- C. Developed over time Illness Injury Auto accident Other _____ I don't know
- D. Developed over time Illness Injury Auto accident Other _____ I don't know

For each condition listed above, please indicate if it is better or worse with any of the following:

- | | | | | | |
|----|--|--|--|--|--|
| | Heat | Cold | Rest | Activity | Other: _____ |
| A. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse |
| B. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse |
| C. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse |
| D. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse |

FRONT

BACK



Please mark the areas of your discomfort on the figures at right, using the symbol which best describes the feeling: +++ sharp, stabbing; 000 pins & needles; VVV dull, aching; /// numbness

Please indicate if your condition limits any of the following activities:

	Normal	Somewhat Limited	Severely Limited
Activity _____			
Lifting _____			
Bending _____			
Standing _____			
Walking _____			
Sitting _____			
Climbing stairs _____			
Running _____			
Resting _____			
Intercourse _____			
Computer work/typing _____			
Normal work _____			
Household activities _____			
Recreational activities _____			
Other _____			

Comments:

Please Continue to Next Page...

Patient to complete the following sections:

Patient Last Name: MI:	First Name:	Date:
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During what time of day do you feel worst? _____

Do you sleep well? Yes No

What are your normal sleeping hours? _____

Are you currently under the care of a medical doctor or other health care provider for any condition?

Yes No Condition: _____

Name of doctor/provider: _____ Phone: _____

Have you ever had an overnight stay in a hospital or surgical procedure of any kind? Yes No

Date and Description: _____

Date and Description: _____

Do you exercise? Yes No

Description: _____ Frequency/Minutes per session: _____

Description: _____ Frequency/Minutes per session: _____

Personal History:

Please read through the following list and check any which may apply to you

•Pain in Body•

- Neck pain with difficulty swallowing
- Extreme neck stiffness with pain or electrical shocks in arms or legs when moving neck
- Leg pain that worsens with exercise but is relieved by resting
- Loss of feeling in inner thighs
- Back pain with urinary problems

•Current Conditions•

- Unable to balance properly
- Recent unexplained weight loss
- Recent progressive muscle weakness or shaking
- Blurred or double vision, dizziness, nausea or faintness when neck is in certain position
- Recent major accident such as a fall from a height, whiplash, or a blow to the head
- Memory loss after injury

•Types of Pain•

- Severe pain interrupts sleep
- Constant pain not improved by changing positions or lying down

•Prior diagnosed condition/Medical History•

- Congenital bone or joint disorder
- Rheumatoid arthritis
- Severe degenerative arthritis
- History of compression fracture
- History of heart attack
- History of stroke or aneurysm
- Past history of cancer or currently diagnosed with cancer
- Diabetes with cold, burning, or numb feet
- Gout
- Lupus
- Ankylosing spondylitis
- Immune suppression due to chemotherapy, organ transplant, etc.
- 3 or more months use of steroid medications or intravenous drugs (past or recent)

Family History

Please read through the following list and check any which apply to you.

- | | | | |
|---|-----------------------------------|---|---|
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizure Disorder |

Notice of Privacy Practices

The **Health Insurance Portability and Accountability Act** concerns the security of your personal and medical information. We respect your privacy and rights, so we follow these guidelines as applicable to our practice.

A partial list of **your rights** includes but is not limited to allowing (or prohibiting) health care providers from **revealing information with your permission, as necessary**, to others involved in your health care, such as insurance carriers, physicians, home care aides, and family members, friends, or other health care proxies who share responsibility for your well-being or billing for services rendered.

Information includes but is not limited to medical records, diagnostic reports, treatments, tests and results, billing, and referrals, as well as personal data such as birthdate, etc.

We will coordinate with all parties necessary for prompt, accurate and effective treatment and proper billing. **We will gladly explain** all aspects of your care to you or assigned persons as you wish.

----- Please sign and return lower portion. -----

Privacy Policies of Artful Chiropractic

The **Health Insurance Portability and Accountability Act (HIPAA)** is in effect. HIPAA has certain requirements with which health care providers are required to comply.

We are required to give each patient a notice of Privacy Practices (see above) listing was in which we might use your Protected Health Information. Please sign below, thereby stating that your received the notice, and return the lower portion to us.

Thank you for helping us comply with these regulations.

Patient Name: (printed) _____

Patient Signature: _____ Date: _____

Release of Information

I certify that the above information is true and correct to the best of my knowledge. I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above other health care professionals to whom I am referred and to the insurance carrier or other entity responsible for payment, utilization and/or quality review for all or a portion of my care and treatments.

Today's date: _____ Signature of patient: _____

If patient required assistance to complete information forms, please sign below and state your relationship to the patient.

Today's date: _____ Signature: _____ Relationship to patient: _____