HEALTHWAYS PATIENT CASE HISTORY

NAME: _____

(last) (first)

RESPONSILE PARTY: _____

(last) (first)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: ___/___/_____ SSN # ____/____/_____ Gender: Male / Female

HOME PH: _____-_____-_____ WORK PH: ____-____-____ CELL PH: ____-____-____

EMAIL ADDRESS: _____

EMPLOYER: _____ PHONE: _____

LIST OF ALLERGIES:

__ Animals __ Aspirin __Chocolate __ Dairy __ Dust __ Eggs __ Latex __ Molds __ Penicillin __ Ragweed/Pollen

__Rubber __ Season Allergies __ Shellfish __Soaps __ Wheat __ X-ray Dye __ Other: _____

LIST OF SURGERIES:

__Back __ Brain __ Elbow __ Foot __Hip __ Knee __Neck __ Neurological __Shoulder __ Wrist

Other: _____

LIST ALL PAST MEDICAL HISTORY CONDITIONS:

__Ankle Pain __ Arm Pain __Arthritis __ Asthma __ Back Pain __ Broken Bones __Cancer __Chest Pain

__Depression__ Diabetes __ Dizziness __ Elbow Pain __ Epilepsy __ Eye/Vision Problems __ Fainting __ Fatigue

__ Foot Pain __Genetic Spinal Condition __ Hand Pain __ Headaches __ Hearing Problems __ Hepatitis

__ High Blood Pressure __Hip Pain __ HIV __ Jaw Pain __ Joint Stiffness __Knee Pain __Leg Pain

__Menstrual Problems __ Mid-Back Pain __ Minor Heart Problem __Multiple Sclerosis __ Neck Pain

__ Neurological Problems __ Pacemaker __Parkinson's __ Polio __ Prostate Problems __ Shoulder Pain

__ Significant Weight Change __ Spinal Cord Injury __ Sprain/Strain – Stroke/Heart Attack

__ Other: _____

LIST TYE OF MEDICATIONS YOU ARE TAKING:

__ Anxiety __ Muscle Relaxers __ Pain Killers __ Insulin __ Birth Control __ Cardiovascular

__ Seizure __ Allergy Medications: _____ Other: _____

Name of medication and dosage _____

LIST YOUR FAMILY HISTORY: Please indicate mother, father, sibling ect.

__ Arthritis __ Asthma __ Back Pain __ Cancer __ Depression __ Diabetes __ Epilepsy

__ Genetic Spinal Conditions __ High Blood Pressure __ Heart Problems __ Multiple Sclerosis

__ Neurological Problems __ Parkinson's __ Polio __ Prostate Problems __ Stroke/Heart Attack

__ Other: _____

HAVE YOU HAD ANY AUTO OR OTHER ACCIDENTS __ NO ___ YES

DESCRIBLE: _____

Date of last physical examination: _____ Do you smoke? __ No __ Yes

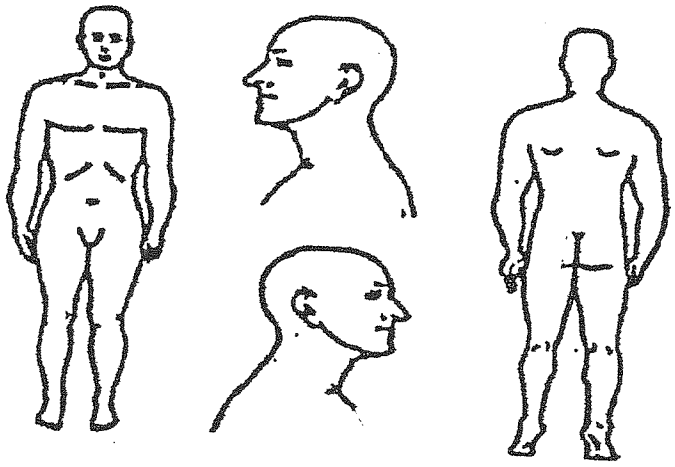
Do you drink alcohol? __ No __ Yes – how many per day? _____

Do you drink caffeine? __No __ Yes- how many per day? _____

Do you exercise? __ No __ Yes (what forms and how often): _____

What is your height _____ Weight _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

__Become pain free

__Explanation of my condition

__Learn how to care for my condition

__Reduce my symptoms

__ Resume normal activity level

What is your major complaint? _____ Date problems began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? __ Getting Better __ Getting Worse __ Not Changing

Have you had this condition in the past? YES / NO

How often do you experience your symptoms?

__ Constantly (76-100% of the day) __ Frequently (51-75% of the day)

__ Occasionally (26-50% of the day) __ Intermittently (0-25% of the day)

Describe the nature of your symptoms: __ Sharp __ Dull __Numb __ Burning __ Shooting __Tingling

__Radiating Pain __ Tightness __Stabbing __Throbbing __ other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

__ 1 __ 2 __3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0=no effect and 10=no possible activities)

__1 __ 2 __3 __4 __5 __6 __7 __ 8 __ 9 __ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

HAVE YOU EVER HAD CHIROPRACTIC CARE? YES___ NO ___

WHEN? _____ WHY? _____

WHERE: _____

WERE X-RAYS TAKEN? YES _____ NO _____

WHENWAS YOUR LAST ADJUSTMENT? _____

HAVE YOU SEEN ANOTHER PROVIDER FOR THIS CONDITION? ALSO PLEASE LIST ANY TEST AND STUDIES THAT HAVE BEEN PERFORMED.

WOULD YOU LIKE A TEXT FOR FUTURE APPOINTMENTS? Y/ N

CELL: (___) _____- _____

WORK: (___) ____-_____

HOME: (___) ____- _____

IF YOU WOULD LIKE FOR US TO PROVIDE THIS SERVICE PLEASE SIGN AND DATE.

SIGNATURE: _____ DATE: _____

Healthways Chiropractic Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other therapy procedures to be performed on myself or on _____ by the doctor. I also consent to the procedures performed by his trained staff assistants under direct instruction and supervision.

I have had an opportunity to discuss with the doctor or other office personnel the nature and purpose of chiropractic adjustments and other therapy procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee to results has been made to, nor relied upon by, me, and I wish to rely on the doctor to exercise judgment during the course of the procedures which he feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic procedures is very low, anyone undergoing chiropractic adjustments, physical therapy services or joint manipulation procedures should know of possible complications, which have been alleged. These include, but are not limited to; burns, fractures, disc injuries, strokes, dislocations, sprains, increase or worsening of symptoms and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had the opportunity to ask questions about its' contents, and by signing below, acknowledge my understanding of its contents.

Date: _____

Patient Name: _____

Patient Signature:_____

Relationship or Authority if not signed by patient:_____

Patient Counseled by use of the following
____Discussion
____Other (Specify)_____

Signature of Doctor or Representative: _____

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: **Danita Deichert**

Address: **1033 Basin Ave., Bismarck, ND 58504**

Telephone No.: **701-223-6613**

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____