Healthways

NAME:_____

EMAIL:_____

RESPONSILE PARTY: _____

(last) (first)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

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

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

EMPLOYER: _____ PHONE: _____

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

DESCRIBLE: _____

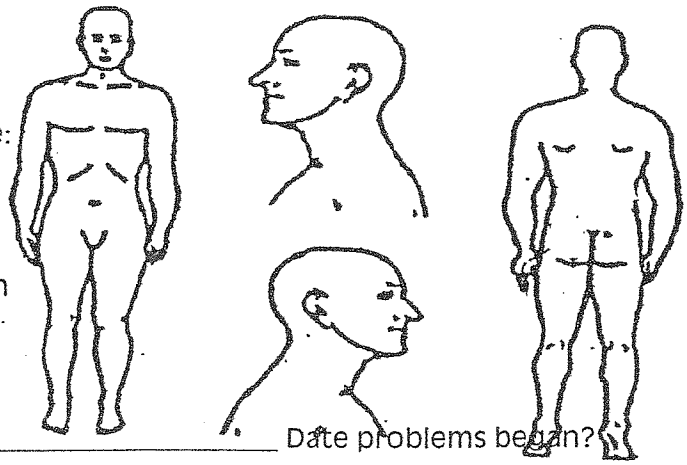
Date of last physical examination:

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?

_____

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 _____

WHEN WAS YOUR LAST ADJUSTMENT? _____

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

CIRCLE ALL ALLERGIES:

Ace Inhibitors	Animal Hair	Antihistamines	Bee Sting
Cat Hair	Cephalosporins	Dog Hair	Egg/Poultry
Environmental Allergy	Fish Product Derivatives	Gluten Protein	Influenza Virus Vaccines
Lactose	Latex	Levodopa	Macrolides
Milk Products	Mumpsvax	Niacin	NSAIDS
Peanut	Penicillins	Pollen	Quinolones
Ragweed	Salicylates	Shellfish	St. John'S Wort
Sulfa (Sulfonamide Antibiotics)	Tetanus Toxoid	Tetracyclines	Tricyclic Compounds
Vitamin C	Watermelon		

Other: _____

ALL MEDICATIONS YOU ARE TAKING:

Name of Medication and Dosage:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please indicate Mother(M), Father(F), Brother(B), Sister (S)
and if alive or deceased (A) (D)

Anemia			Anxiety			Arthritis			Asthma		
BPH			Back Problem			Breast Ca			CAD		
CHF			COPD			Cancer			Cholesterol High		
Dementia			Depression			Dermatitis			Diabetes		
Epilepsy			GERD			Glaucoma			Gout		
HIV			Headache			Hepatitis			Hypertension		
MI			Migraine			Pneumonia			Renal Stone		
Stroke			TB			Thyroid Dz			Ulcer (GI)		

Other: _____

Do you smoke? Yes No Have you ever smoked? Yes No

Cigarettes Cigars Chew Tobacco Dipping Tobacco

Packs much per day? _____ Years used_____ Last used _____

Do you drink alcohol? Yes No

Beer Wine Hard Alcohol

How many per day?_____ Years Used _____ Last used _____

CIRCLE ALL SURGERIES:

AAA Repair	Aortic Aneurysm	Appendectomy	Breast Augment
Breast Reduction	CABG	Carotid Endarterectomy	Cataract Extract
Cesarean Section	Cholecystectomy	Colectomy	Duodenal Ulcer
ESWL	Ectopic Pregnancy	Fracture	Gall Bladder
Gastric Banding	Heart Valve	Hernia Abdominal	Hip Fracture
Hip Surgery	Hysterectomy	Intestinal By-Pass	Knee Arthroscopy
Knee Surgery	LS Spine Surgery	Lasik	Mastectomy
Oophorectomy Uni	PTCA	PVD Procedure	Pacemaker
Prior Surgeries	Prostate Biopsy	Prostatectomy Retro	Should. Arthroscopy
Shoulder Surgery	Sinusectomy (Nasal)	Splenectomy	TURP
Thyroidectomy	Tonsillectomy	Tubal Ligation	Vasectomy

Other_____

CIRCLE ALL PAST MEDICAL HISTORY CONDITIONS:

Anemia	Anxiety	Arthritis	Asthma
BPH	Back Problem	Breast Cancer	CAD
CHF	COPD	Cancer	Cholesterol High
Dementia	Depression	Dermatitis	Diabetes
Epilepsy	GERD	Glaucoma	Gout
HIV	Headache	Hepatitis	Hypertension
MI	Migraine	Pneumonia	Renal Stone
Stroke	TB	Thyroid Disease	Ulcer (GI)

Other_____

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: _____

Privacy Policy

The following page is the last page of the Healthways Patient Privacy Policy. We will need you to sign and date the bottom of the form. If you would like to receive the full copy of this privacy policy, please ask the receptionist and they will be happy to print you a copy. We also have a full copy of the privacy policy in the waiting room and also there is a full copy of the privacy policy on our website. Thank you

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: _____

Healthways medication history authorization

I, _____(patient), authorize Healthways PLLC to access my medication history, if available, through Meditouch software to be added to my Healthways chart.

_____(patient/guardian)

Date_____