Personal History

Date: _____ Email: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Business Phone: _____

Birthdate: _____ Age: _____ Sex: M F

Employer: _____ Type of Work: _____

Marital Status: Married Single Widowed Divorced Separated

Number of Children: _____

Emergency Contact: _____ Phone: _____

Referred By/Found Us: _____

Current Health Condition

Purpose of Appointment: _____

When Did This Condition Begin: _____ Pain Level 1-10 _____

☐ Job Related ☐ Auto Related

Cause of Injury: _____

Current Medications: _____

Past Health History

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia

☐ Broken Bones ☐ Other: _____

Major Accidents or Falls: _____

_____

Hospitalizations: _____

_____

Previous Chiropractic Care: ☐ None

Doctor's Name & Date of Last Visit: _____

Have you been treated for any health condition in the last year? Yes No

If yes, please explain: _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect you overall diagnosis, treatment plan and possibility of being accepted for care.

Check and of the following diseases you have had:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema

Check any of the following you have or have had the <u>past 6 months</u>:

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw

Nervous System Code

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

General Code

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

Gastro-Intestinal Code

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

Genito-Urinary Code

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R Code

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

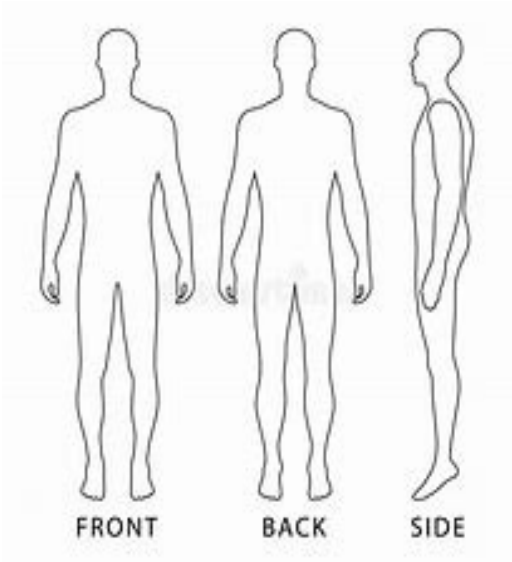
EENT Code

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Male/Female Code

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

Please outline on the diagram the area of your discomfort



Females Only:

When was you last period? _____

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

I authorize Dr. Karen A. Genter, PC to provide medical treatment for any services for myself or my dependents. I also authorize Dr. Karen A. Genter, PC to release information to my insurance company as need for processing the claims I file on my behalf.

_____

Patient or Parent/Guardian Date

Informed Consent

We value a shared decision making process regarding your health needs. As a part of the process you will be informed about the condition of your health and the recommended treatment to be provided to make you better informed in order for you to knowledgably give consent.

Chiropractic is based on the science of the relationship between the spine and function of the nervous system and how this relationship affects the restoration and preservation of health. Adjustments are made to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system where one or more vertebra in the spine misalign and/or does not move properly causing interference and/or irritation to the nervous system. Chiropractors remove and/or reduce nerve interference caused by vertebral subluxation.

During the first visit you will receive a thorough history and an examination that may include a spinal and physical exam, orthopedic and neurological testing, palpation and possibly the first chiropractic adjustment. If x-rays are necessary, you will be referred to a facility that may accept your insurance.

Chiropractic adjustments are the application of precise pressure into the spine in order to reduce or correct vertebral subluxation(s). Most adjustments are delivered by hand but some instrument or other specialized equipment may be utilized. In addition, physiotherapy or rehabilitative procedures may be used. Chiropractic care helps reduce pain, increase mobility and improve quality of life.

Our office is very gentle in our treatments, however risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, fracture, allergic reaction, muscle and/or joint pain. In extremely rare cases there have been reports of stroke associated with visits to medical doctors and chiropractors, although research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke.

I have been informed of the nature and purpose of chiropractic care and the possible consequences and risks of care. Having this knowledge, I knowingly authorize Dr. Karen Genter to proceed with chiropractic treatment.

_____

Print Patient Name

_____ _____

Patient Signature Date

High Desert Chiropractic and Wellness

Consent to use PHI

I agree to allow High Desert Chiropractic and Wellness (HDCW) to use or provide my patient information in order to provide treatment to me, obtain payment for treatment I have received, or to conduct practice operations. I understand that HDCW may not be able to provide treatment to me if I don't sign this document.

I understand I have the right to request a restriction on how my patient information is used or provided. HDCW is not required to agree to the restrictions that I may request. However, if HDCW agrees to a restriction that I request, HDCW and its workforce must not release the restricted information.

I have the right to revoke this consent, in writing, at any time, except to the extent that HDCW has already used or provided my patient information because of my previous consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by HDCW, another health care provider, a health plan, my employer, or a health care clearinghouse. This patient information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review HDCW's *Notice of Privacy Practices* prior to signing this document. HDCW's *Notice of Privacy Practices* has been provided to me. The *Notices of Privacy Practices* describes how my patient information will be used. (The *Notice of Privacy Practices* describes my rights and HDWC's responsibilities with respect to my patient information.)

HDCW reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*. I may request a revised *Notice of Privacy Practices* from my doctor.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Dr. Karen A. Genter

High Desert Chiropractic and Wellness
5310 Homestead Road NE, Suite 202 A, Albuquerque, NM 87110
(505) 292-2226

Financial Office Policy

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Your applicable payment for services is due at the time services are rendered. We accept cash, check, MasterCard, Visa, Discover Card or American Express. Our prices are as follows:

New Patient Visit	***$75***
Existing Patient Visit	***$52***
Child Visit with Paying Adult	***Half Price***
Refer a Family Member/Friend	***Your Next Treatment is Half Price!***

(The State of New Mexico also requires 7.75% tax)

If you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

_____
Signature of Patient/Responsible Party

_____
Date

Missed Appointment Policy

Broken appointments are a loss to everyone. If unable to keep your appointment, please give 24 hours' notice a missed appointment fee will be charged:

$50 for new patients
$25 for existing patients

_____ _____

Signature Date