Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION		
First Name:	Last Name:	Date of Visit:
SS#:	DOB:	Sex:
Marital Status:	# of Children:	Occupation:
Street Address:		Height:
City, State, Zip:		
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Relationship:	Phone:
How did you hear about us?		
Who is your primary care physician?		
Date and reason for your last doctor visit:		
Are you also receiving care from any other health professionals? ○ Yes ○ No If yes, please name them and their specialty:		
Please note any significant family medical history:		

CURRENT HEALTH CONDITIONS
What health condition(s) brought you into our office?
Have you received care for this problem before? ○ Yes ○ No If yes, please explain:
When did the condition(s) first begin?
How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury
Is this condition: ○ Getting Worse ○ Improving ○ Intermittent ○ Constant
What makes the problem better?
What makes the problem worse?

YOUR HEALTH GOALS

Your top three health goals:

1. _____
2. _____
3. _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ○Resolve existing conditions ○Overall wellness ○Both

Have you ever visited a chiropractor? ○ Yes ○ No If yes, what was their name?
What is their specialty? ○ Pain Relief ○Physical Therapy & Rehab ○Nutritional ○ Subluxation-based
○Other:_____

Do you have any health concerns for other family members today?

TRAUMAS: PHYSICAL INJURY HISTORY

Have you ever had any significant falls, surgeries or other injuries as an adult? ○ Yes ○ No
If yes, please explain:

Notable childhood injuries? ○ Yes ○ No
If yes, please explain:

Youth or college sports? ○ Yes ○ No
If yes, list major injuries:

Any auto accidents? ○Yes ○ No
If yes, please explain:

Exercise frequency? ○ None ○1-2x per week ○3-5x per week ○Daily
What types of exercises?

How do you normally sleep? ○ Back ○Side ○Stomach
Do you wake up: ○ Refreshed and ready ○Stiff and tired

Do you commute to work? ○ Yes ○ No If yes, how many minutes per day?

List any problems with flexibility *(ex. Putting on shoes/socks etc.)*

How many hours per day do you typically spend sitting at a desk or on a computer, tablet, or phone?

TOXINS: CHEMICAL AND ENVIRONMENTAL EXPOSURE

Please rate your CONSUMPTION for each with 1 being none and 5 being high:

Alcohol	1 2 3 4 5	Processed Foods	1 2 3 4 5
Water	1 2 3 4 5	Artificial Sweeteners	1 2 3 4 5
Sugar	1 2 3 4 5	Sugary Drinks	1 2 3 4 5
Dairy	1 2 3 4 5	Cigarettes	1 2 3 4 5
Gluten	1 2 3 4 5	Recreational Drugs	1 2 3 4 5

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why:

THOUGHTS: EMOTIONAL STRESSES AND CHALLENGES

Please rate your STRESS for each with 1 being none and 5 being high:

Home	1 2 3 4 5	Money	1 2 3 4 5
Work	1 2 3 4 5	Health	1 2 3 4 5
Life	1 2 3 4 5	Family	1 2 3 4 5

ACKNOWLEDGEMENT AND CONSENT

Regarding: Chiropractic Adjustments, modalities, and therapeutic procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million have been associated with chiropractic adjustments.
Treatment objectives, as well as the risks associated with chiropractic adjustments, and all other procedures provided at Focus Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or techniques that the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Print Name:_____ Date:_____
Sign Name:_____ Date:_____

Regarding: X-rays/imaging studies

Please note: X-rays, are utilized in the office to help with the location and to analyze **vertebral subluxations.** These x-rays are not to be used to investigate for medical pathology. The doctors at Focus Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Print Name:_____ Date:_____
Sign Name:_____ Date:_____

Females Only: *Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

- The first day of my last menstrual cycle was on _____-_____-_____ (Date)
- I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am NOT pregnant.

Print Name:_____ Date:_____

Sign Name:_____ Date:_____

FOCUS CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposed - discussion with other health care providers involved in your care
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For worker's compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public Health and Safety - in order to prevent or lessen a serious imminent threat to the health or safety of a person or the general public.
7. To government agencies or law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased person - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointments reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change in ownership - in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" privacy notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy or your records at no charge, with notice in advance.

FOCUS CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours), X-rays are original records and you are therefore not entitled to them If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:
If you wish to make a formal complaint about how we handle your health information, please call Dr. Andrew Kalis at (407) 906-2127. If he is unavailable, you may make an appointment with our front desk to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of FOCUS CHIROPRACTIC's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding muy rights or any of the information I have received.

Patient's Name:_____ Date:_____ DOB:_____

Patient's Signature:_____ Date:_____

Medical Information Release Form

(HIPAA Release Form)

Name:_____ Date of Birth:_____

Release of Information:

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren)_____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages:

Please call [ ] my home [ ] my work [ ] my cell phone

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day) _____ between (time) _____

Patient's Signature:_____ Date:_____